Nurturing Families Network 2008 Annual Evaluation Report

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Nurturing Families Network: 2008 Annual Evaluation Report

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Nurturing Families Network
Executive Summary

The Nurturing Families Network program, funded by the Connecticut Children's Trust Fund, is a statewide system of continuous care designed to promote positive parenting and reduce incidences of abuse and neglect. The program focuses on high-risk, first-time mothers and starts working with them at or before birth.

In 2007 Nurturing Connections screened 6,735 first-time mothers for risk of poor parenting. In this year's evaluation report, we provide descriptive and outcome information on all families who received services during the 2007 calendar year, including the 1,330 families who received Nurturing Connection services, the 1,342 families who received Nurturing Home Visiting services, and the 519 who attended Nurturing Parenting Groups.

This year's report is divided into six sections: NFN Program Overview, 1995-2007; Statewide NFN Evaluation, 2007; NFN Urban Focus that includes evaluation data for both Hartford NFN and New Haven NFN; State Reports of Child Maltreatment, 2006/2007; Statewide Nurturing Parenting Groups, Statewide Data; and reports on research projects analyzing qualitative data, the *Life Stories Final Report*, and *Revisiting the Cultural Broker Model*.

NFN Program Overview, 1995-2007

This section compares data across program years on the number of first-time mothers who have been screened for services and the number of families who received home visitation by program site. Profiles of high risk mothers, and participation and retention rates are also compared across program years. Analyses of outcome data, specifically, changes in parents' attitudes over time, are presented for all families who participated in the program since program inception in 1995.

Screening First-Time Mothers and Program Participation

- When services began in 1995, there were two program sites. By 1999, when Nurturing Connections, the screening component of NFN, was initiated, there were ten program sites and 1,662 first-time mothers who were screened for services. By the end of 2007, there were 42 program sites across the state and, for the 2007 program year, 6,735 mothers were screened for services.
- The Nurturing Connections component, first established in 1999 as an initial step in providing universal screening of all first-time mothers in Connecticut, is operating out of all 29 birthing hospitals. Since 1999, a total of 34,323 first-time mothers have been screened for services. Screenings are also conducted in clinics and community agencies, and the current goal is to reach as many families as possible at the prenatal stage.
- On average across the years 1999 to 2007, 27% or 9,267 of the first-time mothers who were screened were identified as high risk for poor parenting and abuse and neglect.
- A total of 4,934 families identified as high risk have received home visitation services since 1995. There were 885 active participants at the end of the 2007 program year.

Profiles of High-Risk Families, Program Retention Rates, and Outcome Data

- Program staff have consistently reached and engaged high-risk families as measured by the Kempe Family Stress Checklist. On average across all program years, 59% of these first-time mothers experienced multiple stresses, 55% experienced severe maltreatment as children, 46% showed signs of low self-esteem, and 31% had a history of substance abuse, mental illness, or criminal activity.

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- On average, 74% of families have remained in the program for at least six months, 56% have remained in the program for at least 1 year, and 35% have remained in the program for at least 2 years. The rates are comparable to national retention rates for similar models. Approximately 11% have taken advantage of the program for the full five years.
- Outcome data indicate that families significantly reduced their risk for poor parenting and abuse even when active in the program for only one year. During the course of program participation, mothers have made statistically significant improvements in their attitudes and expectations of their children as measured by the Child Abuse Potential Inventory.

Statewide NFN Evaluation, 2007

In this section of the report we provide 2007 annual data across all NFN programs in the state including enrollment, descriptive, and outcome data for both low risk families who received Nurturing Connections services and high risk family participants who received home visitation.

Nurturing Connections

- The number of families screened for services each year for the past three years has increased, however, the percentage of low risk mothers who were offered services in 2007 and who accepted services has decreased compared to the prior 2 years. This trend will be closely monitored over the next year.
- Program staff reached 1,330 low risk families who entered the program in 2007 and made 1,226 referrals on their behalf, mostly to Infoline, WIC, HUSKY, Mom's Parenting Group, and Help Me Grow. Rate of follow up on referrals was considerably lower this year compared with the prior two years, a finding that warrants examination.

Nurturing Home Visitation

Change in Eligibility Requirements

- In 2007, the intake and referral processes for entering the NFN home visiting program were streamlined. There is now only one screen, the Revised Early Identification (REID) screen, used to determine eligibility for home visiting services. The Kempe Family Stress Checklist has been eliminated as part of the eligibility requirement but is still administered to obtain in-depth information on family backgrounds and current risk factors.
- Home visitation services were offered to 1,347 (60% of families screened at high risk), and of those who were offered services, 572 (42%) first-time mothers and families initiated services.

Risk Profiles

- In comparison with families who entered the program in 2005 and 2006, there is a decrease in the percentage of families scoring at severe risk on the Kempe Family Stress Checklist. However, inspection of REID screens for mothers who scored at lower risk levels on the Kempe showed that: 85% were single, separated or divorce; 78% had inadequate income (or had no information); 42% had less than a HS education; 36% were teenagers; 29% had marital or family problems, and 26% had a history of, or current depression. Although the change in eligibility screening has allowed more mothers to enroll who do not meet the cutoff point on the Kempe (i.e., a score of 20 or below), these are still vulnerable mothers/families who are at high risk for poor parenting.

Retention Rates

- Although the number of participants has increased with program expansion, retention rates (6 month, 1 year, and 2 year) have decreased since 2004; however, these rates are still comparable to national retention rates for similar models. In addition, families have participated in home visitation an average of 22 months across all program sites that have provided services since at least 2002 (the maximum five-year program time).

Rates of program acceptance and retention are higher for mothers screened at the prenatal stage than mothers screened postpartum indicating that, indeed, as research at the national level suggests, first-

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- time mothers may be more receptive when offered services during their pregnancy versus after they have their baby.

Program Outcomes

- Similar to analyses from prior years, mothers who participated in the program for one and two years made statistically significant improvements on the CAPI-Rigidity subscale indicating they have less rigid expectations of their children and are less likely to treat their children forcefully.
- Mothers who received one and two years of service made statistically significant improvement in community life skills in the areas of transportation, budgeting, accessing support services, involving support from others, and in the organization and regularity of routines. They also made significant progress in life course outcomes including education, employment, and independent living.
- Documentation on fathers' outcomes are limited primarily because information is often collected from the mothers; these data are therefore difficult to interpret.

NFN Urban Focus

In 2005, Hartford was targeted as the first city in Connecticut to "go to scale"- that is, to screen all first-time mothers for home visitation services in the city, and in 2007, New Haven was the second city to go to scale. This strategy is an attempt to target parenting practices among vulnerable families who often reside in resource-deprived neighborhoods.

Hartford NFN

Similar to statewide data, this section reports on enrollment, descriptive, and outcome data for families participating in home visitation within Hartford NFN.

Program Capacity and Enrollment of High Risk Families

- In 2007, there were 1,796 initial screens completed in Hartford and 564 (or 31%) of these first-time mothers were identified as high risk for poor parenting; 194 (or 34%) initiated services.
- The percentage of Hartford families who are offered home visitation services has declined from 98% in 2005, and 91% in 2006 to 73% in 2007, indicating that many of the Hartford NFN programs are becoming filled to capacity since first going to scale in 2005.

Risk Profiles

- Similar to the statewide data, in comparison with 2005 and 2006, there was an increase in the percentage of families scoring at Low Risk on the Kempe Family Stress Checklist for the Hartford families. Although the change in eligibility screening has apparently allowed more mothers to enroll who do not meet the cutoff point on the Kempe (i.e., a score of 20 or below), inspection of the REID screens indicate that these mothers are still at risk for poor parenting and child maltreatment. The REID screens showed that 82% were single, separated or divorced; 80% had inadequate income (or had no information); 39% had less than a HS education; 36% were teenage mothers; 29% had marital or family problems; and 20% had a history of or current depression.

Hartford NFN Program Outcomes

- Hartford NFN mothers significantly reduced their risk for maltreatment as measured by the CAPI-Rigidity subscale at 6 months, 1 year, and 2 years participation time. This was true even when active in the program for only six months. These data indicate that mothers have less rigid expectations of their children and are less likely to treat them forcefully.
- Similarly, Hartford mothers showed a statistically significant change in their self-reports of depression as measured by the CES-Depression scale. Average scores not only significantly decreased for each of the analyses (mothers participating at 6 months, 1 year and 2 years) but actually decreased to below the cut-off point of 16 even when mothers were active for only six months.

New Haven NFN

New Haven NFN initiated screening and intake in October of 2007. In order to gain an understanding of the context in which the New Haven NFN programs are providing services, we report on regional and

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neighborhood statistical information comparable to a similar analysis of Hartford in prior reports. Preliminary analyses on data collected from October-December of 2007 are also presented.

Regional Inequality

- Like Hartford, New Haven has a high concentration of parents living in poverty. In comparison to the other 20 towns in the region, New Haven stands alone as having by far the highest rates of poverty at 24.4 percent.
- At $35,950, New Haven's average median family income is only 49 percent of the regional average, $73,540.
- There is a total of 5,377 children, birth to 5 years of age, who live in poverty in the region. Sixty-two percent, or 3,334 of these children, reside in New Haven.

Enrollment Rates

- There were a total of 235 mothers who were screened for services in New Haven from October to December 2007; 133 of these first-time mothers were identified as low risk for poor parenting; 57 of these families were offered Nurturing Connections services and 24 accepted services.
- There were 102 first time mothers identified as high risk for poor parenting (43% of the total screens); the majority (99 families) were offered home visiting and 41 families initiated services between October and December of 2007.

Risk Profiles

- Descriptive data were provided on only a small sample size at the end of 2007; however, the sum of these preliminary data indicate that this is a vulnerable group. All but one mother are not married; more than one half are teenagers; more than one half are residing with the maternal grandmother; and almost one half of these mothers have less than a high school education. Most of these families have financial difficulties as reported by the home visitors. Fifteen of 24 of these mothers' self-reports on the CES-Depression scale indicated they were experiencing depression.
- As with the statewide and Hartford data, there was a relatively high percentage of New Haven NFN families that scored as Low Risk on the Kempe Family Stress Checklist; however, given these other risk indicators, once again this appears to be due to a change in eligibility requirements.

Community Referrals

- Similar to the Hartford NFN program, community referrals are documented to assess service needs and the networks that NFN home visitation is part of. Home visitors made 52 referrals from October through December of 2007 in support of NFN families. Most of the referrals were to address basic needs (WIC, DSS, SS, Household) or were related to employment and education. Families followed up on 67% or 35 of these referrals.

State Reports of Child Maltreatment, 2006/2007

Similar to prior years we report on both substantiated and unsubstantiated reports of abuse and neglect for all families, statewide, who signed a release allowing us to search the Department of Children and Families (DCF) database to determine if there were any reports of maltreatment during their tenure in the home visitation program. We also take a closer look at the discipline methods used by Hartford NFN families in this section, including self reports of abuse and neglect as measured by the Parent-Child version of the Conflict Tactics Scale (CTS-PC). We cross reference these particular cases of self-reported child maltreatment with state reports.

Summary of Reports of Abuse and Neglect

- The annual rate of child maltreatment this year, 4.4 percent, indicates an increase in the 2006-2007 time period as compared to the previous two years; the rates peaked in 2002-2003 and 2003-2004, then declined for the next two years before increasing this year.
- Physical neglect was by far the most prevalent type of maltreatment that occurred (80% of all substantiated cases), followed by emotional neglect.
- NFN mothers were perpetrators in 86 percent of all reports and 75 percent of substantiated cases.

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- Fathers were involved in 37 percent of all cases, but in 44 percent of substantiated cases.
- Families, on average, had been in the NFN program for 10 months when a substantiated report was filed and home visitors made 17 percent of these reports.
- As in previous years, domestic violence and drug use were common reasons why reports were made. Slightly more than one-third of all substantiated cases involved a parent with a mental illness or cognitive delay, about one-third of these reports involved domestic violence and another one-fifth substance use.
- Hartford NFN mothers' self reports on their discipline methods on the Parent-Child version of the Conflict Tactics Scale (CTS-PC) have been collected for two cohorts: participants entering the program in 2005 and 2006. A small number of these mothers reported "acts of physical assault" and "neglect" of their child on the CTS-PC. Of the 11 mothers who made these reports, one of them had a substantiated state report of maltreatment, and two had unsubstantiated DCF reports.

Nurturing Parenting Groups, Statewide Data

The Nurturing Parenting Groups make up the third component of the Nurturing Families Network. In this section we report on the social demographic characteristics of the group participants, attendance rates by type of curricula, and parent outcomes.

- There were several different curricula that sites used in 2007, with most choosing the Birth to Five and Prenatal curricula. Rates of graduation differed by the type of curricula used. Completion rates ranged from 49 percent (Birth to Five curricula) to 90 percent (Community Based Education in Nurturing Parenting).
- Prenatal parents showed significant and positive change on the Adult-Adolescent Parenting Inventory suggesting that, overall, parents displayed healthier parenting attitudes and more age appropriate expectations of their children upon completion of the groups.
- There were statistically significant changes in the desired direction on the Overall Stress scale on the Parenting Stress Index-Short Form (PSI-SF), as well as the Parent-Child Dysfunctional Interaction and Difficult Child subscales. These scores indicate that parents were experiencing greater parenting competence and less stress in their parental roles.

Research Projects

In this section, two reports are presented that highlight findings from qualitative research. In *Life Stories Final Report,* four topics are explored: childcare needs and barriers; the effects of child sexual abuse; high school completion among adolescent mothers; and the unique vulnerabilities of very young mothers. These issues were explored to better understand the ways that the NFN program can address the needs of this population. What we learn from the mothers themselves is that one of the most important roles the home visitor can play is to develop a strong trusting relationship with the mother. It is through this relationship that the home visitor can help empower young mothers to advocate for their children, to seek help recovering from past and present trauma so they can end the cycle of abuse, to return to school or continue their education so they can better provide for their children, and to develop the emotional maturity necessary to be an effective and nurturing parent.

In *Revisiting the Cultural Broker Model*, data from focus group discussions with Hartford NFN program staff are presented. The focus groups were designed to elucidate the decision processes of the home visitors in identifying family needs and helping families obtain resources and connect to community services. Analyses of these data highlight both the central importance of the home visitor in developing a strong trusting relationship with the mother and the pivotal role of the clinical supervisor for making the paraprofessional model more effective. This model is the mechanism for creating meaningful change in the lives of these vulnerable families and as such, should be revisited and further refined to address the very issues that often challenge home visitation practice.

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Introduction

Overview of Report

This report is divided into six sections. The first section, **NFN Program Overview, 1995-2007**, gives a brief description of the evolution and components of the program including Nurturing Connections, Home Visitation, and Nurturing Parenting Groups, and reports on *NFN's aggregate* data for all families who participated in NFN since program inception.

The second and third sections report on *NFN's 2007 annual data*. Section two, **NFN Statewide Annual Evaluation, 2007**, reports on data across all program sites statewide. Section three, **NFN Urban Focus**, **2007**, reports on the progress of the 11 program sites in Hartford, the first city to go to scale in 2005, and the 8 program sites in New Haven, the second city to go to scale in 2007. In these sections, enrollment, descriptive, and outcome data are examined for low-risk families who received Nurturing Connections services and high-risk families who received home visitation.

In the fourth section, **State Reports of Child Maltreatment, 2006/2007,** we report on both substantiated and unsubstantiated reports of abuse and neglect for NFN home visitation families, statewide. We also take a closer look at the discipline methods used by Hartford families in this section as measured by the Parent-Child version of the Conflict Tactics Scale (CTS-PC).

The fifth section, **Statewide Nurturing Parenting Groups**, reports on NFN's community-based parenting education and support groups offered to both low-risk and high-risk families.

In the sixth section, **Research Projects,** two reports are presented that highlight findings from qualitative research: the *Life Stories Final Report* and *Revisiting the Cultural Broker Model.*

Analyses of data

Where applicable, family profiles, program participation rates, and outcome data are compared across several years showing trends over time. By charting program performance in the same areas over time, the performance history serves as a basis for judgment; that is, prior performance serves as a benchmark for current performance. In addition, we use a pre-post design and analyze change in the areas that the program is attempting to impact by testing mean scores (or averages) at different points in time for statistical significance using a repeated measures analysis of variance test. Key findings from analyses are highlighted for the following sections: aggregate data across time (since program inception), statewide annual data, Hartford annual data, and New Haven annual data. Findings from the examination of abuse and neglect reports are also summarized. The qualitative analyses in the final section of the report complements the pre-post quantitative data and provides an interpretive framework for understanding how the program creates change.

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NFN Program Overview 1995-2007

In this section we describe the Nurturing Families Network, the different components of the program and how families are enrolled. We compare data across program years on the number of first time mothers who have been screened for services and the number of families who received home visitation by program site. Risk profiles, and participation and retention rates are also compared across program years. Analyses of outcome data, specifically change in parents' attitudes over time, is presented for all families who participated in the program since program inception.

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NFN Statewide System of Care

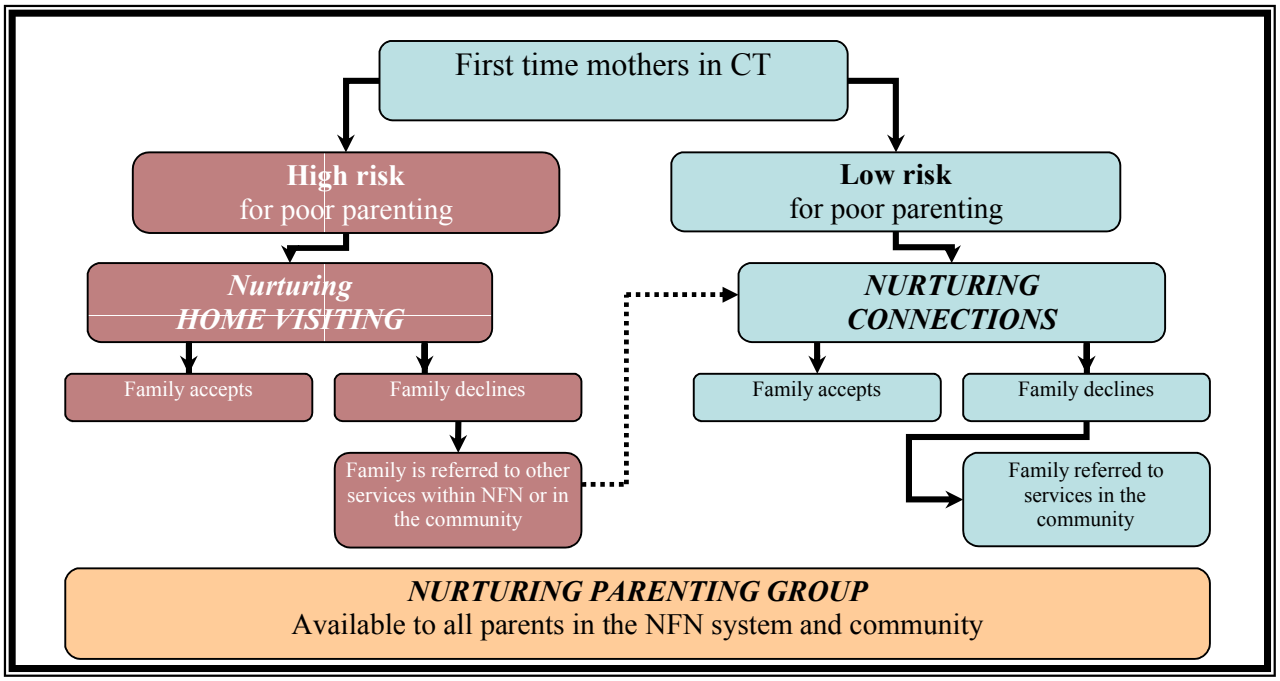

Figure 1. NFN System of Care

The Nurturing Families Network is designed to provide a continuum of services for families in the state. The Flowchart illustrates how families enter the NFN system and the various path they may follow. All NFN services are voluntary, thus there are many steps at which families can either refuse services or be referred to other community services.

NFN Program Components

NFN's mission is to work in partnership with first-time parents by enhancing strengths, providing information and education, and connecting them to services in the community when needed. It is made up of three components: Nurturing Connections, Nurturing Parenting Groups, and Nurturing Home Visiting Program.

- ***Nurturing Connections*** is the gateway into NFN. Nurturing Connections staff conduct the screening of all first-time mothers, identifying parents at low risk or high risk for poor parenting and child maltreatment. Nurturing Connections staff also provide telephone support and referral services for low-risk mothers.
- ***Nurturing Home Visiting*** program provides high-risk families intensive parent education and support in the home and also helps to link families with needed resources and assistance for up to 5 yrs.
- ***Nurturing Parenting Groups*** are community-based parenting education and support groups offered to all families at various risk levels, including all parents who enter the NFN system as well as parents in the community.

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Nurturing Connections: Screening First Time Mothers 1999-2007

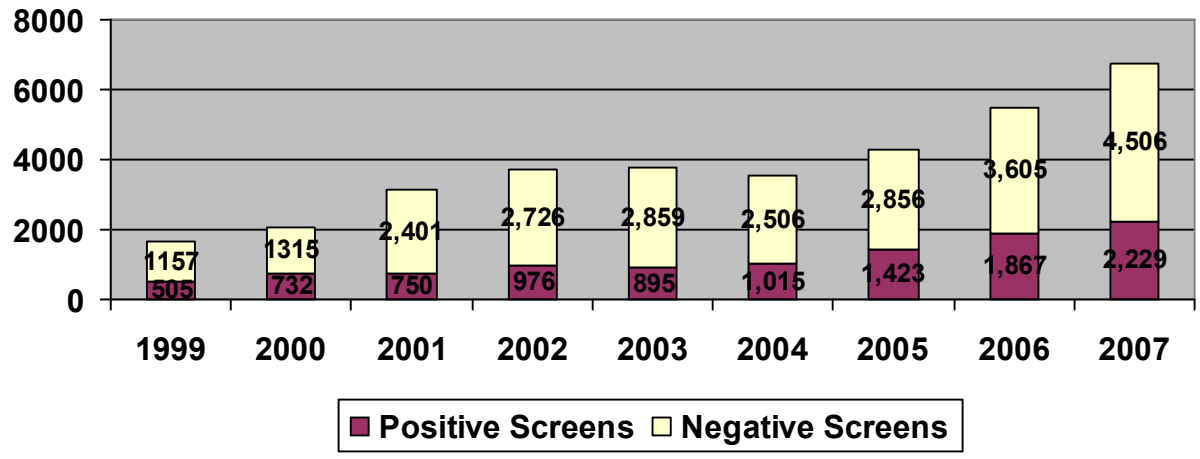
The Nurturing Connections component was first established in 1999 as an initial step in providing universal screening of all first- time mothers in Connecticut. It is operating out of all 29 birthing hospitals. Screenings are also conducted in clinics and community agencies, and the current goal is to reach as many families as possible at the prenatal stage. As shown, the Revised Early Identification (REID) screen, used to determine eligibility, consists of 17 items that research has shown increases the probability of child maltreatment. In order to screen positive (i.e., high risk) on the REID, a person must have either (a) three or more characteristics, or (b) two or more characteristics if one of them is item number 8, 11, 14, or 15, or (c) have 8 or more characteristics.

The percentages of first-time mothers that scored as high risk by year are as follows: 1999– 30%, 2000– 36%, 2001– 24%, 2002– 26%, 2003– 24%, 2004– 29%, 2005– 33%, 2006– 34%, and 2007– 33%. On average, 27% of these families have been identified as high risk. In 2007, 6,735 first-time mothers were screened; 4,506 were identified as low risk, and 2,229 were identified as high risk.

Figure 2 shows that as the program sites expanded across the state, there has been a comparative increase in screenings. The biggest increase occurred with the expansion in Hartford (2005), and a similar expansion is expected over the next one to two years as New Haven increases their services (starting in 2007).

The Revised Early Identification (REID) Screen for Determining Eligibility
1. Mother is single, separated, or divorced
2. Partner is unemployed
3. Inadequate income or no information
4. Unstable housing
5. No phone
6. Education under 12 years
7. Inadequate emergency contacts
8. History of substance abuse
9. Late, none, or poor prenatal care
10. History of abortions
11. History of psychiatric care
12. Abortion unsuccessfully sought or attempted
13. Adoption sought or attempted
14. Marital or family problems
15. History of, or current depression
16. Mother is age 18 or younger
17. Mother has a cognitive deficit

Figure 2. Number of First Time Mothers Screened, 1999-2007



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Program Sites and Families Served Since 1995

Table 1 shows that by the end of 2007, there was a total of 42 home visiting sites statewide and 4,655 families have received home visiting services since NFN program inception in 1995. (Note that the total number of families served at NFN sites excludes 49 families who received services at more than one site.) As of the end of 2007, there were 885 families who were active participants.

In 2007 there were four new sites added within New Haven, the second city to go to scale (after the Hartford expansion in 2005): City of New Haven Health Department, Children's Community Programs, Fair Haven, Hill Health, St. Raphael's Hospital. Additional program sites were added at UCONN Health Center in Farmington, Johnson Memorial Hospital in Somers.

Table 1. Number of Families Served at Each Program Site Statewide

Program Sites	First Year Offered Services	Number of Families Served	Active Families as of end of 2007
Hartford VNA	1995	486*	46
WellPath (Waterbury)	1995	390*	42
So. Central VNA (New Haven)**	1996	308	34
Bridgeport Child Guidance Center*	1996	481*	53
ECHN (Manchester)	1996	357	36
Lawrence & Memorial Hospital (New London)	1998	163	16
Yale/New Haven Hospital**	1998	232	40
Families Network of Western CT (Danbury)	1998	214	22
Family Strides (Torrington)*	1999	233*	42
Generations, Inc. (Willimantic)	1999	178	32
Hartford Hospital	1999	Connections & Group services only	
Family & Children's Agency (Norwalk)	2000	138	33
Madonna Place (Norwich)	2000	155	17
Hospital of Central Connecticut (New Britain)	2000	128	27
Family Centers (Stamford)	2000	102	14
St. Francis Hospital**	2000	142*	36
Community Health Center (Meriden)	2002	105	37
Middlesex Hospital	2002	92	25
StayWell Health Center (Waterbury)	2002	126	27
Day Kimball Hospital (Putnam)	2005	63	21
Family Centers (Greenwich)	2006	30	15
Bristol Hospital	2006	44	24
4C's (New Haven)	2006	51	30
Asylum Hill (Hartford)	2005	59	23
El Centro (Hartford)	2005	50	25
Hispanic Health Council (Hartford)	2005	42	26
MIOP (Hartford)	2005	83	32
Parkville (Hartford)	2005	61	33
RAMBUH (Hartford)	2005	44	16
Southside (Hartford)	2005	70	17
Trust House (Hartford)	2005	51	18
New Milford VNA	2007	3	3
UCONN Health Center (Farmington)	2007	UNK	UNK
Johnson Memorial Hospital (Somers)	2007	0	0
City of New Haven Health Department	2007	6	6
Children's Community Programs (New Haven)	2007	8	8
Fair Haven (New Haven)	2007	2	1
Hill Health (New Haven)*	2007	8	8
St. Raphael's Hospital (New Haven)	2008	0	0
	TOTAL	4,934	885

* These sites cover two hospitals/service areas ** This site have more home visitors than other sites

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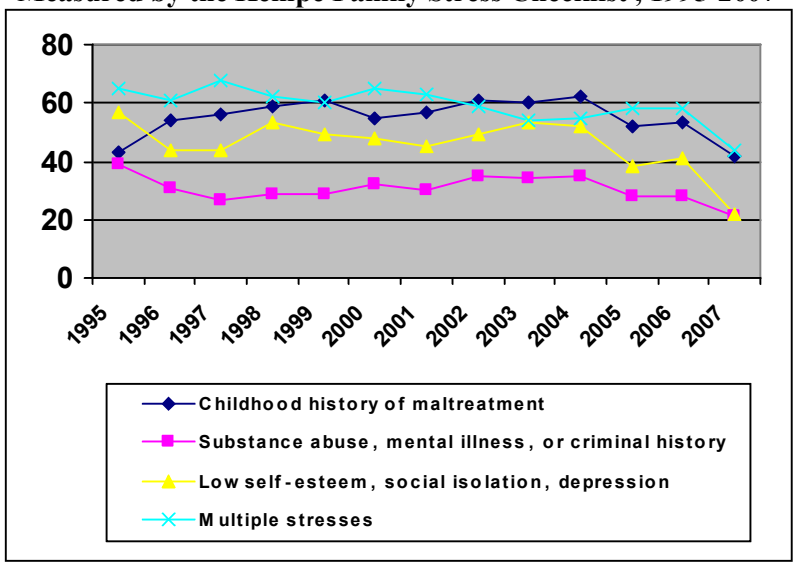
Reaching and Engaging High Risk Families
NFN Home Visitation, 1995-2007

Starting in 1995 the Nurturing Home Visitation program has consistently reached a vulnerable population and provided them with intensive services.

Percentage of Mothers Scoring at Severe Risk at Program Entry

Figure 3 shows the percentage of mothers scoring at severe risk on the Kempe Family Stress Checklist for each program year. On average, 59% of these first-time mothers experienced multiple stresses, 55% experienced severe maltreatment as children, 46% showed signs of low self-esteem, and 31% had a history of substance abuse, mental illness, or criminal activity.

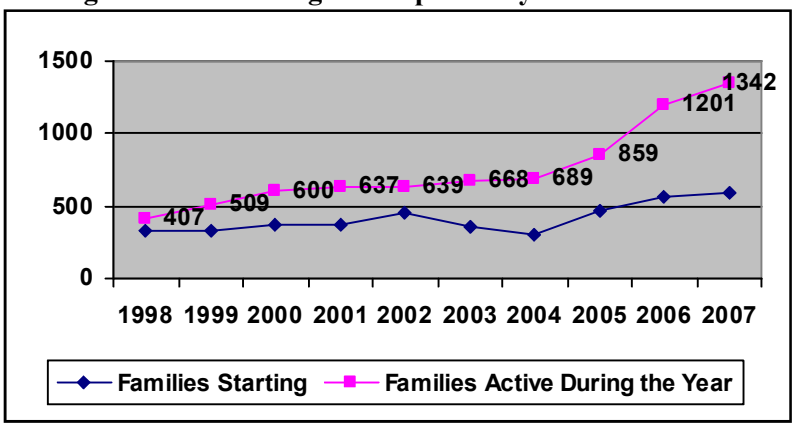
Fig 3. Percentage of Mothers Scoring at Severe Risk as Measured by the Kempe Family Stress Checklist , 1995-2007



Home Visiting Participation by Year Since 1998

As the program sites expanded across the state, there has been a comparative increase in screenings and participation in the home visiting program. Figure 4 shows the biggest increase occurred with the expansion in Hartford in 2005 and a similar increase is expected with the expansion in New Haven in 2007.

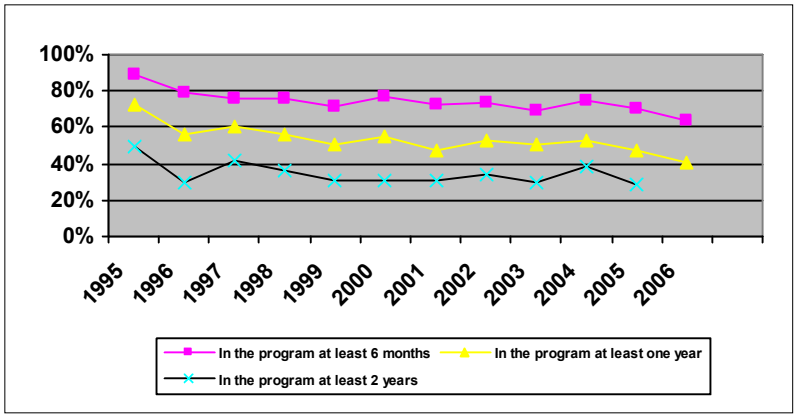
Fig 4. Home Visiting Participation by Year Since 1998



Program Retention Rates: 6 Months, 1 Year, 2 Years.

Families receive intensive services in the home (~ 2x monthly) and help with accessing community resources for up to 5 years. Figure 5 shows 6 months, 1 yr. and 2 yr. retention rates for each cohort for every program year since its inception in 1995. On average, 74% of families have remained in the program for at least six months, 56% have remained in the program for at least 1 year, and 35% have remained in the program for at least 2 years. About 11% have taken advantage of the program for the full five years.

Fig 5. Program Retention Rates by Year of Program Entry



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Change in Parenting Attitudes Over Time, NFN Home Visitation, 1995-2007

Table 2. Change in Parenting Attitudes for 1, 2 3, 4 and 5 Year Participants, 1995-2007

1 Year CAPI Scores N=1091	Program Entry	1 Year
Abuse (Total)	154.6	138.0***
Distress	88.0	76.2***
Rigidity	24.7	19.7***
Unhappiness	15.3	16.9***
Problems with child & self	1.3	1.6**
Problems with family	11.5	11..3
Problems from others	12.1	11..3**

2 Year CAPI Scores N=512	Program Entry	1 Year	2 Year
Abuse (Total)	152.1	135.6	122.6***
Distress	86.4	74.0	65.8***
Rigidity	24.5	19.4	16.8***
Unhappiness	14.8	16.2	15.8
Problems with child & self	1.3	1.6	1.7
Problems with family	11.6	12.1	10.8
Problems from others	12.0	11.4	10.3***

3 Year CAPI Scores N=259	Program Entry	1 Year	2 Year	3 Year
Abuse (Total)	142.7	129.9	118.5	116.1***
Distress	81.2	71.1	62.3	60.6***
Rigidity	22.9	17.7	16.0	15.7***
Unhappiness	14.1	16.3	15.4	17.3
Problems with child & self	1.4	1.6	1.5	2.0
Problems with family	10.4	11.4	11.5	9.9
Problems from others	11.4	11.0	10.3	9.6*

4 Year CAPI Scores N=129	Program Entry	1 Year	2 Year	3 Year	4 Year
Abuse (Total)	147.1	133.3	122.0	119.4	122.2*
Distress	83.3	73.3	65.2	16.5	15.2***
Rigidity	22.9	17.4	15.7	16.5	15.2***
Unhappiness	15.0	16.8	16.3	17.9	17.9
Problems with child & self	1.7	2.0	2.2	2.5	2.5
Problems with family	10.5	11.0	11.0	9.8	11.1
Problems from others	12.2	11.2	10.6	9.5	9.6*

5 Year CAPI Scores N=66	Program Entry	1 Year	2 Year	3 Year	4 Year	5 Year
Abuse (Total)	145.6	134.7	127.5	118.4	116.8	96.4**
Distress	83.5	77.2	71.9	61.6	61.9	48.6**
Rigidity	22.6	16.7	16.0	16.2	16.1	15.0*
Unhappiness	13.7	16.4	15.3	16.7	15.8	13.6
Problems with child & self	1.7	1.9	1.8	2.2	2.5	1.5
Problems with family	10.4	10.1	10.0	9.4	10.1	9.0
Problems from others	12.8	11.5	11.1	9.9	9.3	8.5*

*p<.05 **p<.01 ***p<.001

In Table 2 we present outcome data on the Child Abuse Potential Inventory (CAPI), a self-report standardized instrument designed to measure someone's potential to maltreat children, for all families who participated in NFN since program inception in 1995.

Outcome data indicates that families significantly reduced their risk for poor parenting and abuse even when active in the program for only one year.

Data on the total Abuse scale, and each of the subscales were analyzed separately (in a repeated measures analysis of variance) for mothers active for one year (N=1091), two years (N=512), three years (N=259), four years (N=129), and five years (N=66) and who had completed the CAPI for each year that they participated.

- There was a significant decrease in the average total Abuse score from entrance to final year of participation for each analysis and the average total score dropped for five year participants from 145.6 to 96.4. (Scale average for general population is 91)

- For the Rigidity subscale specifically, there was a significant decrease in average scores from entrance to every subsequent year analysis.

- Similar to previous analyses, there were changes on the Unhappiness and Problems with Child & Self in the undesired direction.

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Program Overview, Summary of Key Findings, 1995-2007

Screenings and Program Participation

The Nurturing Families Network, a system of care that provides a continuum of services to first-time mothers, has expanded across the state over the past 12 years. With this expansion there has been a comparative increase in screenings and program participation.

- In 1995 there were two program sites and 1,662 first time mothers who were screened for services; by 2007 there were 42 program sites across the state and 6,735 mothers who were screened for services.
- The Nurturing Connections component, first established in 1999 as an initial step in providing universal screening of all first-time mothers in Connecticut, is operating out of all 29 birthing hospitals. Screenings are also conducted in clinics and community agencies, and the current goal is to reach as many families as possible at the prenatal stage. Since 1999, a total of 34,323 first-time mothers have been screened for services. On average, across the years 1999 to 2007, 27% or 9,267 of the first-time mothers who were screened, were identified as high risk for poor parenting and abuse and neglect.
- A total of 4,934 families identified as high risk have received home visitation services since 1995. There were 885 active participants at the end of the 2007 program year.

Risk Profiles, Retention Rates, and Outcome Data

The program has consistently reached a vulnerable population, provided them with intensive services, and overall has yielded positive results.

- Program staff have reached and engaged high risk families as measured by the Kempe Family Stress Checklist. On average across all program years, 59% of these first-time mothers experienced multiple stresses, 55% experienced severe maltreatment as children, 46% showed signs of low self-esteem, and 31% had a history of substance abuse, mental illness, or criminal activity.
- On average, 74% of families have remained in the program for at least six months, 56% have remained in the program for at least 1 year, and 35% have remained in the program for at least 2 years.
- During the course of program participation, mothers have made statistically significant improvements in their attitudes and expectations of their children as measured by the Child Abuse Potential Inventory. These outcome data indicate that families significantly reduced their risk for poor parenting and abuse even when active in the program for only one year.

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Statewide NFN Annual Evaluation, 2007

In this section of the report we provide 2007 annual data across all NFN programs in the state. Screening, enrollment, and services for both low-risk and high-risk families are examined. Family profiles, including risk factors, social demographic characteristics, household data, and education and employment information are described for families receiving home visitation services. Data on program participation and rates of retention as well as parent outcomes are analyzed.

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Nurturing Connections Services for Low Risk Families Statewide Data, 2007

Disposition of Nurturing Connections Screens

In 2007, 2,946 out of 4,506 mothers identified as low risk (65%) were offered telephone support and referral services, and of those offered, 1,767 (60%) accepted services. Table 3 shows that the number of families screened each year for the past 3 years has increased, however, the percentage of low risk mothers who were offered services in 2007 and who accepted services, has decreased compared to the prior 2 yrs.

Nurturing Connections: Program Services

Nurturing Connections staff made an average of 4.6 calls to each of the participating families (see Table 4). Eliminating the families whom staff were unable to contact after they left the hospital, they reached a total number of 1330 who started services in 2007 and provided 1,226 referrals, mostly to Infoline, WIC, HUSKY, Mom's Parenting Group, and Help Me Grow (for a total number of 499 referrals and 40% of all referrals). As shown in Table 4, rate of follow up on referrals was considerably lower this year compared with the prior 2 years - 29% versus 62% in 2006 and 70% in 2005, a finding that warrants examination.

NC Participant Characteristics

For 2007, Nurturing Connections mothers were, on average, 27 years of age at the time of the child's birth, slightly younger than the average age of fathers (31years). Slightly more than one-half of mothers and fathers are White, 53% and 56% respectively, and a little more than 20% are Hispanic. Table 5 shows these data are similar with findings from the prior two years.

Table 3. Disposition of NFN Families Identified as Low Risk, Statewide Data, 2005-2007

Families Identified as Low Risk	2005 N=2856	2006 N=3605	2007 N=4506
Offered Nurturing Connections	2319 (81%)	2851 (79%)	2946 (65%)
Accepted Nurturing Connections	1597 (69%)	1861 (65%)	1767 (60%)

Table 4. Nurturing Connections Program Services 2005-2007	**2005**	**2006**	**2007**
Number of Families Who Participated	1782	1198	1712
Avg. # of Calls Attempted per Family	8.8	6.3	7.7
% of Families Unable to Reach	14%	21%	22%
Avg. # of Contacts-Calls per Family	5.2	3.5	4.6
# of Referrals to Resources	**2005**	**2006**	**2007**
Infoline	279	47	105
WIC	236	45	125
HUSKY	208	9	105
Nurturing Group	16	14	18
NFN Home Visiting	19	15	23
Care 4 Kids	22	5	22
Mom's Parenting group	30	39	67
Department of Social Services	18	31	10
La Leche League	13	13	25
Help Me Grow	14	7	97
Other	782	389	629
Total	1637	614	1226
Rate of Follow-up on Referrals	70%	62%	29%

Table 5. NC Participant Characteristics 2005-2007

Mother's Age	**2005**	**2006**	**2007**
Under 16 years	<1%	<1%	1%
16-19 years	12%	10%	12%
20-22 years	16%	16%	14%
23-25 years	15%	14%	15%
26-30 years	26%	30%	30%
Over 30 years	31%	30%	29%
Mean Age	27 yrs	27 yrs	27 yrs
Mother Race/Ethnicity	**2005**	**2006**	**2007**
White	51%	62%	53%
Hispanic	22%	19%	21%
African American	14%	9%	11%
Native American	0%	<1%	<1%
Asian	3%	3%	3%
Multi-racial	<1%	<1%	<1%
Other	7%	7%	8%
Father's Age			
Under 16 years	<1%	0%	<1%
16-19 years	5%	4%	6%
20-22 years	10%	10%	8%
23-25 years	14%	11%	12%
26-30 years	24%	26%	29%
Over 30 years	47%	50%	46%
Mean Age	30 yrs	31 yrs	31 yrs
Father's Race/Ethnicity	**2005**	**2006**	**2007**
White	54%	62%	56%
Hispanic	23%	19%	22%
African American	11%	9%	11%
Native American	0%	0%	<1%
Asian	3%	3%	3%
Multi-racial	<1%	<1%	1%
Other	9%	7%	8%

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High Risk Families and Enrollment in Home Visitation Statewide Data, 2007

Disposition of High Risk Screens

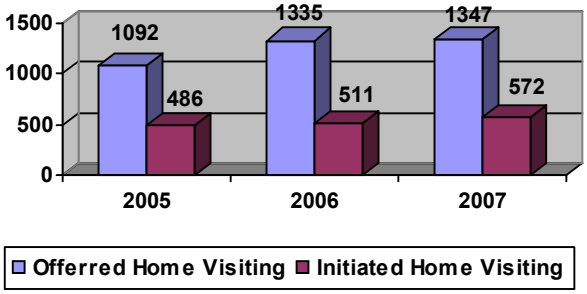
In 2007, the intake and referral processes for entering the NFN home visiting program were streamlined. There is now only one screen, the Revised Early Identification (REID) screen, used to determine eligibility for home visiting services. The Kempe Family Stress Checklist has been eliminated as part of the eligibility requirement but is still administered to obtain in-depth information on family backgrounds and current risk factors

- As already noted, there were 6,735 first-time mothers screened in 2007 and of those, 2,229 (33%) were identified as high risk.
- Services are offered based on program capacity. Table 5 shows that for 2007, services were offered to 1,347 (60% of families screened at high risk), and of those who were offered services, 572 (42%) first-time mothers and families initiated services.
- In situations where home visitation was filled to capacity, an additional 533 mothers who were identified as high risk were offered Nurturing Connections services (telephone support and referral information) and 346 of these first-time mothers accepted services.

Table 6. Disposition of NFN Families Identified as High Risk, Statewide Data, 2005-2007

Families Identified as High Risk	2005	2006	2007
Number Identified	**N=1423**	**N=2021**	**N=2229**
Offered Home Visiting	1092 (77%)	1476 (73%)	1347 (60%)
Initiated Home Visiting	486 (45%)	579 (39%)	572 (42%)
Offered Nurturing Connections	349 (24%)	403 (22%)	533 (24%)
Accepted Nurturing Connections	286 (82%)	361 (90%)	346 (65%)

Fig 6. Statewide Home Visiting Services, 2005-2007: # of families offered services, # of families who accepted



Enrollment rates for program years 2005-2007

- Table 5 and Figure 6 compares last year's data with the prior two years. There is an increase in screenings and a slight increase in the number of families initiating services, however, the percentage of families offered services decreased. Once offered services, the percentage (and number) of families who initiated home visitation increased slightly from 2006.

Mothers Scores on the Kempe Family Stress Checklist

The subscales on the Kempe assessment provide a more nuanced risk profile of participating families.

- As noted in Table 7, 42% of first-time mothers screened in

(cont. on p. 13)

Table 7. Mothers' Kempe Scores Statewide Data, 2007	0 Low Risk	5 Moderate Risk	10 Severe Risk
1. Childhood History of Abuse/Neglect (N=600)	40%	18%	42%
2. History of Crime, Substance Abuse, Mental Illness (N=599)	49%	28%	23%
3. CPS History (N=598)	93%	4%	3%
4. Low Self-esteem/ Social Isolation/ Depression (N=602)	20%	58%	22%
5. Multiple Stresses (N=599)	17%	40%	43%
6. Potential for Violence (N=591)	81%	8%	11%
7. Unrealistic Expectation of Child (N=593)	60%	33%	7%
8. Harsh Punishment (N=587)	83%	13%	4%
9. Negative Perception of Child (N=589)	87%	11%	2%
10. Child Unwanted/ Poor Bonding (N=601)	15%	74%	11%

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Risk Profiles: Mothers' Kempe Scores, Statewide, 2005-2007

2007 scored at severe risk on the Childhood History of Abuse/Neglect subscale and an additional 18% scored at moderate risk. A severe rating includes mothers who were severely beaten, abandoned, or sexually abused as children but also mothers who were raised by *more* than two families.

- Forty-three percent of these first-time mothers scored at severe risk for Multiple Stresses, which examines stress related to living situations, housing, relationships, and financial status, and an additional 40% scored at moderate risk.
- For Low Self-Esteem/Social Isolation/Depression, a multiple construct, 22% of the mothers scored at severe risk and an additional 58% scored at moderate risk.
- For History of Crime/ Substance Abuse/Mental Illness, 23% of the mothers screened in 2007 scored at severe risk and an additional 28% scored at moderate risk.
- Seventy-four mothers scored at moderate risk on Child Unwanted/Poor Bonding and 33% scored at moderate risk for Unrealistic Expectation of Child.

Mothers' Scores on the Kempe for program years 2005-2007

- In comparison with families who entered the program in 2005 and 2006, there is a comparatively significant decrease in the percentage of families scoring at severe risk (see Figure 7).
- Table 8 also shows that there is a much larger percentage of families that scored 20 or below: 32% scored at Low Risk in 2007 in comparison with 5% and 6% in 2005 and 2006 respectively.

Fig. 7. Statewide NFN Mothers Scoring at Severe Risk as Measured by the Kempe Family Stress Checklist, 2005-2007

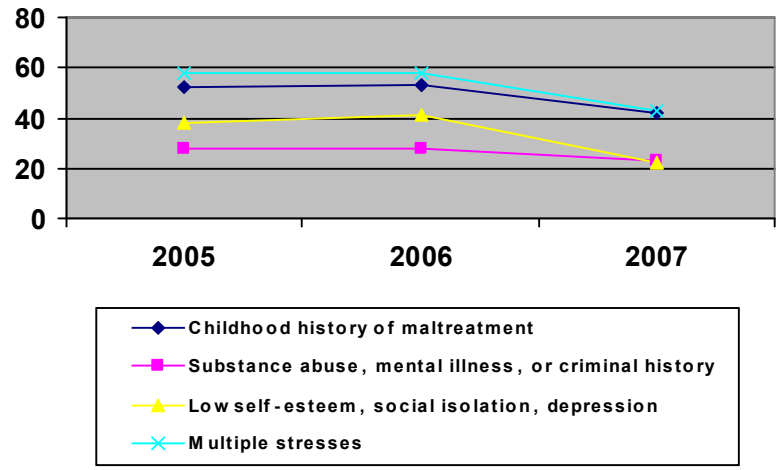

Table 8. Mothers' Scores on the Kempe Family Stress Checklist, 2005-2007

Risk Level on the Kempe	2005	2006	2007
	N=419	N=536	N=597
Low-risk (0-20)	5%	6%	32%
Moderate risk (25-25)	50%	51%	39%
High-risk (40-60)	40%	39%	27%
Severe risk (65-100)	5%	5%	2%
Mean	39	38	30

Mothers who Scored at Low Risk on Kempe

Given the above data and the change in eligibility requirements as already noted, these findings warrant further examination. Inspection of REID screens for mothers who scored at Low Risk on the Kempe showed that

- 85% were single, separated or divorced,
- 78% had inadequate income (or had no information),
- 42% had less than a HS education,
- 36% were teenagers,
- 29% had marital or family problems, and
- 26% had a history of, or current depression.

Inspection of ratings for these same mothers on the Child Abuse Potential Inventory (completed after initiating services) as represented in Table 9, showed that while these mothers scored much lower on the Abuse and Distress scales, their scores on the Rigidity scale were comparable, even higher than the high risk.

Table 9. CAPI Scores by Kempe Risk Profiles, Statewide Data, 2007

CAPI Scale	Low Risk Score 0-20	High Risk Score 25+
Abuse	102.3	135.2
Distress	46.6	76.4
Rigidity	25.4	20.9

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Home Visitation Families at Program Entry
Statewide Data, 2007

Mothers' Household Information

Home visitors document families' demographic data within the first month of program involvement. Similar to the risk profiles, social demographic characteristics recorded at the time NFN families enter the program also demonstrate high levels of family vulnerability.

- Table 10 shows 89% of the parents had never been married and 45% were teen mothers.

Table 10. Household Data, Statewide, 2007

Families Screened Prenatally (N=591)	40%
Mother's Marital Status (N=585)	
Single, never married	89%
Married	9%
Divorced, separated, widowed	2%
Mother's Race/Ethnicity (N=572)	
White	26%
African American	14%
Hispanic	38%
Other (e.g., multi-racial)	23%
Mother Age at Baby's Birth (N=472)	
Under 16 years	6%
16-19 years	39%
20-22 years	23%
23-25 years	14%
26 years and older	19%
Median Age	21 years
Maternal Grandmother Living in the Household (N=575)	21%
Father Living in the Household (N=575)	62%
Father's Involvement With Child (N=299)	
Very involved	58%
Somewhat involved	16%
Sees child occasionally	6%
Very rarely involved	1%
Does not see baby at all	18%

Table 11. Mothers' Social Problems/Risk Factors, 2005-2007

Mother's Social Isolation, Arrest Histories, and Financial Difficulties	2005 N=394	2006 N=503	2007 N=519
Mothers socially isolated	42%	44%	30%
Mothers with arrest history	18%	19%	13%
Mothers with financial difficulties	74%	75%	66%
Mothers receiving TANF	18%	17%	10%
Mothers receiving food stamps	34%	31%	25%

- Maternal grandmothers were living in the household for 21% of these families, and fathers were living in 62% of the households.
- Seventy-four percent of the fathers were at least somewhat involved, and more than half of the fathers (58%) were very involved as reported by the mothers at program entry.
- As with former years, NFN families are racially diverse with Hispanic families representing the largest racial/ethnic group (38%), followed by Whites (26%), Other, including multi-racial (23%) and African American (14%)

Mothers' Social/Risk Factors

- As shown in Table 11, home visitors considered 66% of these mothers to have financial difficulties and 30% to be socially isolated at time of program entry.
- Although these data indicate a high degree of vulnerability amongst these mothers, these percentages are not as high in comparison with the same data for the 2005 and 2006 cohorts. There is a similar trend for percentages of mothers receiving TANF, food stamps, and with an arrest history.

Mothers' Pregnancy & Birth Information

Beginning in October of 2007, a range of data on health related risk factors have been collected.

- Health data in Table 12 indicate that 12% of NFN children were born with serious medical problems;
- 12% were born premature, and 10% of the NFN children had a low birth weight.
- Nine percent of the mothers smoked cigarettes during pregnancy.
- Almost all the children have a pediatrician (96%).

Table 12. Mothers' Pregnancy & Birth Information: Oct –Dec 2007 (N=77)

Mother smoked cigarettes during pregnancy	9%
Mother drank alcohol during pregnancy	1%
Mother used illicit drugs during pregnancy	4%
Child born with serious medical problems	12%
Born Prematurely (before 37 weeks gestation)	12%
Born Low Birth weight (under 5 lbs 8 oz)	10%
Child has a Pediatrician	
Yes	96%
No	1%
Unknown	3%

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Education and Employment Rates at Program Entry
Statewide Data, 2007

Table 13. Mothers' Life Course, Statewide, 2007	19 and younger	20 and older
Mother Education	**(N=206)**	**(N=255)**
Eighth grade or less	6%	5%
More than 8th grade, < high school	67%	19%
High school degree or GED	22%	38%
Some vocational training or college	6%	30%
College degree or graduate work	0%	8%
Mother Enrolled in School	**(N=210)**	**(N=258)**
Yes	52%	11%
Employment Status	**(N=211)**	**(N=258)**
Mother not employed	84%	74%
Mother employed	16%	26%
Full-time	1%	16%
Part-time job or occasional work	14%	10%
Employed Prior to Pregnancy	**(N=196)**	**(N=247)**
Yes	33%	72%

Table 14. Fathers' Life Course, Statewide, 2007	19 and younger	20 and older
Father Education	**(N=25)**	**(N=63)**
Eighth grade or less	8%	5%
More than 8th grade, < than HS	52%	16%
High school degree or GED	36%	51%
Some vocational training or college	4%	19%
College degree or graduate work	0%	10%
Father Enrolled in School	**(N=31)**	**(N=114)**
Yes	45%	7%
Employment Status	**(N=55)**	**(N=176)**
Father not employed	47%	28%
Father employed	53%	72%
Full-time	30%	47%
Part-time job, occasional work, or working more than one job	23%	25%
Fathers With an Arrest History	**(N=47)**	**(N=166)**
Yes	40%	36%
Fathers Currently Incarcerated	**(N=54)**	**(N=174)**
Yes	11%	4%

Mothers' Life Course Information

Mothers' education and employment data are presented in Table 13, separating mothers who were 19 years or younger when they had their child from those who were 20 and older.

- Seventy-two percent of the younger cohort of mothers had less than a high school education at program entry; however, 52% were still enrolled in some type of school. Twenty-four percent of the older cohort had not completed high school.
- Thirty-three percent of the younger cohort of mothers were employed prior to pregnancy; only 16% remained employed around the time of birth. For the older cohort, 72% were employed prior to pregnancy and only 26% of these older mothers were employed at program entry.

Fathers' Life Course Information

Our data on fathers are limited, primarily because home visitors rely on mothers to provide information on fathers if the father is not part of the home visits. As with mothers' data, we analyzed employment and educational data by father's age at baby's birth (see Table 14)

- For the younger cohort, 60% of the fathers had less than a high school education, however, 45% were still enrolled in school. For the older cohort, 21% had less than a high school education and 7% were enrolled in school; 29% of the older cohort of fathers had some post-secondary education (either vocational training or a college degree)
- Forty-seven percent of the younger cohort and 28% of the older cohort of fathers were not employed.
- Of the fathers that we have data on, 40% of the younger cohort and 36% of the older cohort had an arrest history, and 11% and 4% respectively were incarcerated at the time of the baby's birth.

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Home Visitation Participation, Statewide Data, 2007

Table 15. Program Participation Rates, 2005-2007

Frequency of Home Visits & Program Participation	2005 N=931	2006 N=1176	2007 N=1342
Average # of attempted home visits	2.0	2.7	2.9
Average # of completed home visits	1.4	2.0	2.1
Average # of office/out of home visits	0.2	0.2	0.2
Average # of NFN social events attended	0.2	0.1	0.1
Total # of visits completed	1.8	2.3	2.4

As of the end of 2007, there were 1,342 families who were active at the program sites.

Fig 8. Six month, 1 year, and 2 year Program Retention Rates

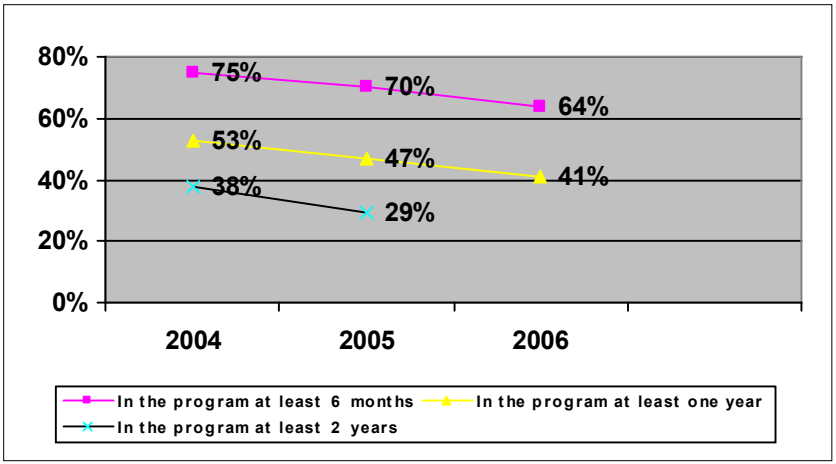

Table 16. Reasons Families Leave the Program, 2005-2007

Reasons Families Left NFN Home Visiting	2005 N=343	2006 N=541	2007 N=560
Family moved out of service area	16%	20%	15%
Unable to locate mother	23%	28%	32%
Discharged, family was noncompliant	6%	1%	0%
Family decided to discontinue services	16%	16%	15%
Mother is working or in school full-time, no time for home visits	11%	14%	15%
Goals were met/family graduated	12%	3%	9%
Baby removed from home by DCF	4%	3%	3%
Discharged, family was not appropriate for the program	1%	1%	1%
Other family member did not approve of services	1%	1%	1%
Home visitor left the program	0%	1%	1%
Other	6%	7%	8%

Program Participation Rates

Program services consist mostly of home visits and, on average, a family receives two visits per month as shown in Table 15. Families also receive visits outside of the home and attend program events. Rates of program participation in 2007 are similar to the previous year and a significant increase from 2005. It is important to note that the increase in average number of home visits parallels the increase in average number of attempted visits.

Program Retention Rates

Six month, one year, and two year retention rates are shown in Figure 8 by year. For mothers who entered the program in 2006, 64% remained in the program for 6 months and 41% remained in the program for 1 year. Going back to 2005, 29% of mothers entering the program participated for 2 years. Although the number of participants have increased with program expansion, retention rates (6 mo., 1 yr., 2 yr.) have decreased since 2004.

Average Retention Rate Across Program Sites

The average retention rate across all program sites that initiated services at least 5 years ago (maximum program time) were calculated. On average, families participated for 22 months; it will be important to monitor the above-noted declining trend in the annual retention rates over the next several years.

Reasons Families Leave the Program

As shown in Table 16, the main reasons families leave the program is because the family moved without informing program staff (and were unable to be located) or they informed staff they were moving but it was out of the service area. Families also leave the program when the mother is not available for services (working or in school) or the family otherwise made a decision to leave the program, and because the family met program goals.

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Home Visitation Participation by Prenatal Status, 2007

Table 17.
2007 Enrollment Rates: Low Risk Mothers Entering Program Prenatally vs Post Partum

2007 Negative Screens	Prenatal	Postpartum
Total # of Negative Screens	179	4327
Offered Nurturing Connections	125 (70%)	2821 (65%)
Accepted Nurturing Connections	94 (75%)	1673 (59%)

Table 18.
2007 Enrollment Rates: High Risk Mothers Entering Program Prenatally vs Postpartum

2007 Positive Screens	Prenatal	Postpartum
# of Positive Screens	463	1766
Families Offered Home Visiting	412 (89%)	935 (53%)
Accepted Home Visiting	232 (56%)	426 (46%)
Received Kempe	231 (~100%)	418 (98%)
Initiated Home Visiting Services	214 (93%)	358 (86%)

By operating out of all 29 birthing hospitals, NFN program staff can facilitate services during the immediate postpartum period. However, when possible, the goal is to reach families at the prenatal stage when first time mothers are perhaps more receptive to services, and also to help families position themselves for better care for their children.

Enrollment Rates by Prenatal Status

- Table 17 shows that 179 mothers identified as low risk were screened at the prenatal stage (vs. 4327 screened postpartum). Out of those who were offered telephone support and referral services, 75% accepted in comparison with 59% of mothers who were screened during the immediate postpartum stage (see Figure 9).
- Table 18 shows that for mothers identified as high risk, 463 were screened at the prenatal stage (vs. 1766 screened postpartum), and 56% of mothers screened at the prenatal stage accepted home visiting compared with 46% of the mothers who were screened at postpartum (see Figure 9).

Program Retention Rates by Prenatal Status

- Figure 10 compares 6 month, 1 year, and 2 year retention rates as of 2007 for mothers who started the program at the prenatal stage versus immediate postpartum. For mothers who entered the program during the prenatal stage, 88% remained in the program for 6 months, 45% remained in the program for 1 year, and 31% for 2 years compared with 59%, 37%, and 28%, respectively, for mothers who entered the program postpartum.

Fig. 9. 2007 Families Screened at Prenatal vs. Postpartum Who Accepted Services

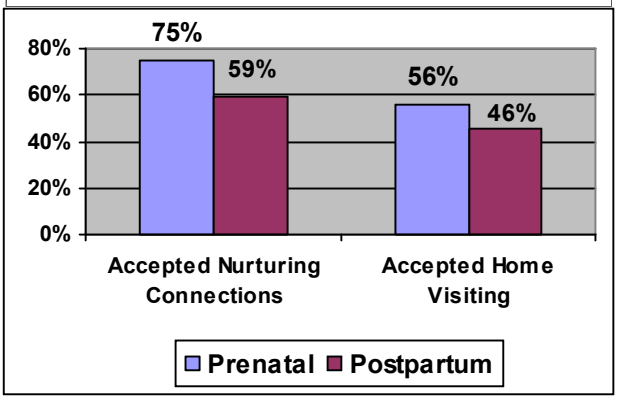
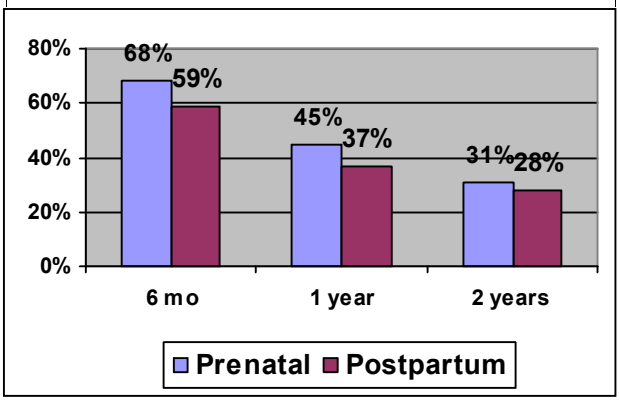


Fig. 10. 2007 Retention Rates for Mothers Entering Program Prenatal vs. Postpartum



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Change in Utilization of Community Resources
Statewide Parent Outcomes, 2007

Community Life Skills Scale

The Community Life Skills (CLS) scale is a self-report standardized instrument that measures someone's knowledge and use of resources in his/her community. The CLS produces an overall score as well as scores on six subscales: Transportation, Budgeting, Support Services, Support Involvement, Interests/Hobbies, and Regularity/Organization/Routines. The overall (Total) score on the CLS ranges from 0-33, with higher scores indicating more effective use of community resources. As shown in Table 19, Data on the Total CLS scale and each of the subscales were analyzed separately (in a repeated measures analysis of variance) for mothers active for one year (N= 383) and for two years (N=100) and who completed the survey for each year they participated.

- Analyses for both one and two year participants showed statistically significant changes on the Total scale and on the majority of the subscales.
- Improvement in community skills was documented in the areas of transportation, budgeting, accessing support services, involving support from others, and in the organization and regularity of routines.
- The one exception concerns the use of resources to satisfy personal interests and hobbies. These findings are very similar to results in prior years.

Table 19. Change in Mean Scores on the Community Life Skills for 1 & 2 Yr Participants

Community Life Skills Scale (N=383)	Program Entry	1 Year
Total	23.2	25.5***
Transportation	3.2	3.6*
Budgeting	3.0	3.5***
Support services	4.1	4.5***
Support/Involvement	4.1	4.8***
Interests/Hobbies	2.6	2.7
Regularity/Organization/ Routines	6.3	6.5**

Community Life Skills Scale (N=100)	Program Entry	1 Year	2 Year
Total	22.9	25.8	25.7***
Transportation	3.2	3.5	3.5*
Budgeting	3.0	3.7	3.7***
Support services	4.2	4.6	4.5***
Support/Involvement	3.8	4.8	4.9***
Interests/Hobbies	2.6	2.7	2.7
Regularity/Organization/ Routines	6.1	6.5	6.4*

*p<.05 **p<.01 ***p<.001

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Change in Mothers' Life Course Outcomes
Statewide Data, 2007

Home visitors complete a questionnaire annually for each family active in the program from which we derive life course outcomes. As shown in Table 20, change in each of the life course outcomes was analyzed separately (in a repeated measures analysis of variance) for mothers active for one year (N= 213) and two years (N=95), who completed the questionnaire each year they participated. (Note: Different N size is due to missing data.)

Education, Employment, Independent Living

- Mothers who received one year of service, made significant progress in life course outcomes: rates of high school education, employment, independent living and state support increased.
- Mothers who received two years of service also made significant progress in employment and independent living.

Financial Difficulties

Rates of mothers who experience financial difficulties decrease but still remain consistently high with no statistically significant change from year to year.

- Rates of financially difficulty were 74% and 70% at program entry and as high as 68% and only as low as 60% for participants who were active in the program for one year and two years, respectively.
- Use of government assistance increased for 1 year participants but for 2 year participants there was a decline in the 2nd year, most likely attributable to state time limits.

Social Isolation

- Mothers' isolation, one of the strongest predictors of child abuse and neglect, significantly decreased for both 1 year and 2 year participants.

Table 20. Change in Mothers' Life Course Outcomes for 1 & 2 Year Participants, Statewide Data

Mothers' Living Circumstances: 2006-2007	N	Entry	1 Year
Mothers with at least a high school education	213	48%	55%***
Mothers employed	211	20%	36%***
Mothers employed full-time	211	9%	7%
Mothers receiving child support (formal or informal)	144	20%	33%**
Mothers enrolled in school	213	29%	28%
Mothers experiencing financial difficulties	200	74%	68%
Mothers socially isolated	203	45%	25%***
Mothers living independently of family	200	40%	52%**
Mothers receiving TANF	164	12%	21%**
Mothers receiving Food Stamps	164	31%	49%***
Mothers receiving WIC	164	82%	90%*

Mothers' Living Circumstances: 2005-2007	N	Entry	1 Yr	2 Yr
Mothers with at least a high school education	86	47%	51%	52%
Mothers employed	93	22%	37%	44%***
Mothers employed full-time	93	4%	5%	6%
Mothers receiving child support (formal or informal)	55	24%	29%	31%
Mothers enrolled in school	95	18%	29%	22%
Mothers experiencing financial difficulties	88	70%	67%	60%
Mothers socially isolated	85	47%	21%	15%***
Mothers living independently of family	89	42%	45%	78%***
Mothers receiving TANF	76	18%	30%	21%
Mothers receiving Food Stamps	76	32%	47%	41%
Mothers receiving WIC	76	84%	86%	83%

*p<.05 **p<.01 ***p<.001

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Change in Fathers' Life Course Outcomes
Statewide Data, 2007

Father Life Outcomes

As already noted, our data on fathers are limited primarily because information is often collected from the mothers if fathers are not part of the home visits. For this reason, the data should be interpreted with caution. Separate analyses were conducted for families receiving 1 year and 2 years of service by the end of 2007, and for whom data was collected on fathers for each year of participation. Similar to data collected on mothers, Table 21 shows change in fathers' living circumstances. Information collected on fathers also includes their involvement with their children, (not at all, rarely, occasionally, somewhat, very involved), often as rated by the mothers. Past research has shown that mothers tend to rate father involvement low than fathers do (see Life Stories Report, 2004).

Education and Employment

- For families that participated for one year and two years as of 2007, there were no significant improvements in fathers' educational achievement or rates of employment.
- For families that were active in the program for 1 year, fathers' rates of school enrollment declined, possibly due to age (i.e., young adult).

Financial Difficulties

- Rates of fathers who experience financial difficulties are lower than rates for mothers, and decrease.
- However, rates of fathers experiencing financial difficulties at the end of 1 and 2 years of program participation are still 56% and 46% respectively.
- Fathers' involvement with their children significantly declined for families who received services for 1 year.

Social Isolation

- Fathers' isolation decreased for both 1 and 2 year participants; for 2nd yr participants, there was a statistically significant decrease indicating that fathers were experiencing better connections with others; however these data were not well documented (sample size=36).

Involvement with Children

- Table 21 indicates that fathers' involvement with their children significantly decreased for 1 year participants but remained the same and relatively high (at least 73% were somewhat involved) for 2 yr. participants.

Table 21. Change in Fathers' Life Course Outcomes for 1 & 2 Year Participants

Fathers' Living Circumstances, 2006-2007	N	Entry	1 Year
Fathers with at least a high school education	117	50%	50%
Fathers employed	145	66%	67%
Fathers employed full-time	145	12%	14%
Fathers enrolled in school	142	17%	9%**
Fathers with financial difficulties	99	62%	56%
Fathers socially isolated	94	20%	15%
Fathers at least somewhat involved with their children	123	72%	61%*

Fathers' Living Circumstances, 2005-2007	N	Entry	1 Year	2 Year
Fathers with at least a high school education	41	39%	37%	41%
Fathers employed	65	65%	66%	63%
Fathers employed full-time	65	11%	12%	5%
Fathers enrolled in school	69	9%	6%	4%
Fathers with financial difficulties	41	68%	41%	46%*
Fathers socially isolated	36	23%	28%	14%*
Fathers at least somewhat involved with their children	56	79%	75%	73%

*p<.05 **p<.01 ***p<.001

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Change in Mothers' Attitude & Potential for Abuse Statewide Data, 2007

As stated, the Child Abuse Potential Inventory (CAPI) is a widely used and well-researched instrument. It produces an overall Abuse score as well as six subscale scores: Distress, Rigidity, Unhappiness, Problems with Child and Self, Problems with Family, and Problems with Others.

In this section we report on data for mothers who had been active in the program for one year (N=121) and two years (N=54), by the end of 2007 and who had completed the CAPI for each year that they participated. The total Abuse scale and each of the subscales were analyzed separately in a repeated measures analysis of variance.

Rigidity Subscale

A significant decrease on the Rigidity subscale reveals that a mother is less likely to feel that her children should *always* be neat, orderly, and obedient. Mothers who have less rigid expectations of their children are less likely to treat their children forcefully.

- As shown in Table 22, mothers who participated in the program for one and two years made statistically significant improvements on the Rigidity subscale.

Abuse & Distress Subscales

- In addition there was positive change on the total Abuse scale and the Distress scale for both 1 and 2 year participants, but the change was not statistically significant.

Unhappiness & Problems with Child & Self Subscales

- For each of the analyses, there is change in the undesired direction on the Unhappiness and Problems with Child & Self subscales, although not statistically significant. It is possible that because children are making significant developmental changes such as walking and developing a sense of independence they are possibly perceived as more difficult by their mothers.

Table 22. Change in Means Scores on the Child Abuse Potential Inventory for 1 and 2 year participants, Statewide Data, 2007

CAPI Scores (N=121) 2006-2007	Entry	1 Year
Abuse (Total)	145.7	131.0
Distress	84.6	72.8
Rigidity	28.8	20.5*
Unhappiness	14.4	16.4
Problems with child & self	.09	1.2
Problems with family	10.6	9.7
Problems from others	11.3	10.3

CAPI Scores (N=54) 2005-2007	Entry	1 Year	2 Year
Abuse (Total)	145.5	138.5	134.0
Distress	80.7	72.9	76.0
Rigidity	27.1	24.0	19.1**
Unhappiness	14.3	17.0	16.2
Problems with child & self	1.1	1.9	3.0*
Problems with family	11.5	10.4	8.3
Problems from others	10.9	12.3	10.8

*p<.05 **p<.01

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Statewide NFN Evaluation, Summary of Key Findings

Nurturing Connections

- The number of families screened for services each year for the past 3 years has increased, however, the percentage of low risk mothers who were offered services in 2007 and who accepted services, has decreased compared to the prior 2 years. This trend will be closely monitored over the next year.
- Program staff reached 1,330 low risk families who entered the program in 2007 and made 1,226 referrals on their behalf, mostly to Infoline, WIC, HUSKY, Mom's Parenting Group, and Help Me Grow. Rate of follow up on referrals was considerably lower this year compared with the prior 2 years - 29% versus 62% in 2006 and 70% in 2005, a finding that warrants examination.

Nurturing Home Visitation

Risk Profiles

- Home visitation services were offered to 1,347 (60% of families screened at high risk), and of those who were offered services, 572 (42%) first-time mothers and families initiated services.
- In comparison with families who entered the program in 2005 and 2006, there is a comparatively significant decrease in the percentage of families scoring at severe risk on the Kempe Family Stress Checklist. However, inspection of REID screens for mothers who scored at lower risk levels on the Kempe showed that: 85% were single, separated or divorce; 78% had inadequate income (or had no information); 42% had less than a HS education; 36% were teenagers; 29% had marital or family problems, and 26% had a history of, or current depression. In addition, a comparison of mothers' entry scores on the CAPI-Rigidity subscale showed these families were comparable, even slightly higher than the families who scored at High Risk on the Kempe Family Stress Checklist. Although the change in eligibility screening has allowed more mothers to enroll who do not meet the cutoff point on the Kempe (i.e., a score of 20 or below), these are still vulnerable mothers/families who are at high risk for poor parenting.

Retention Rates

- Although the number of participants have increased with program expansion, retention rates (6 mo., 1 yr., 2 yr.) have decreased since 2004, however, the rates are still comparable to national retention rates for similar models (Gomby, 2007). In addition, families have participated in home visitation on average for 22 months across all program sites that have provided services since at least 2002 (the maximum five-year program time). It will be important to closely monitor the trend in the 6 month and annual retention rates, and the average length of stay in the program over the next several years.
- Rates of program acceptance and retention are higher for mothers screened at the prenatal stage than mothers screened postpartum indicating that indeed, as research at the national level suggests, first-time mothers may be more receptive when offered services during their pregnancy versus after they have their baby.

Program Outcomes

- Mothers who received 1 and 2 years of service made statistically significant improvement in community life skills in the areas of transportation, budgeting, accessing support services, involving support from others, and in the organization and regularity of routines. They also made significant progress in life course outcomes including education, employment, and independent living.
- Documentation on fathers' outcomes are limited primarily because information is often collected from the mothers; these data are therefore difficult to interpret.
- Typical to analyses in prior years, mothers who participated in the program for one and two years made statistically significant improvements on the CAPI-Rigidity subscale indicating they have less rigid expectations of their children and are less likely to treat their children forcefully.

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NFN Urban Focus, 2007

In 2005, Hartford was targeted as the first city in Connecticut to "go to scale"- that is, to screen all first-time mothers for home visitation services in the city. Accordingly, the NFN home visitation program was expanded from 2 to 10 program sites within Hartford. Six of these sites also run Neighborhood Family Centers funded by the Hartford Foundation for Public Giving. In 2007, New Haven was the second city to go to scale, going from 3 to 8 program sites (also see Table 1). This strategy is an attempt to target parenting practices among vulnerable families who often reside in resource-deprived neighborhoods. Included with the urban data, are figures mapping the residences of NFN families within the neighborhoods for the two cities.

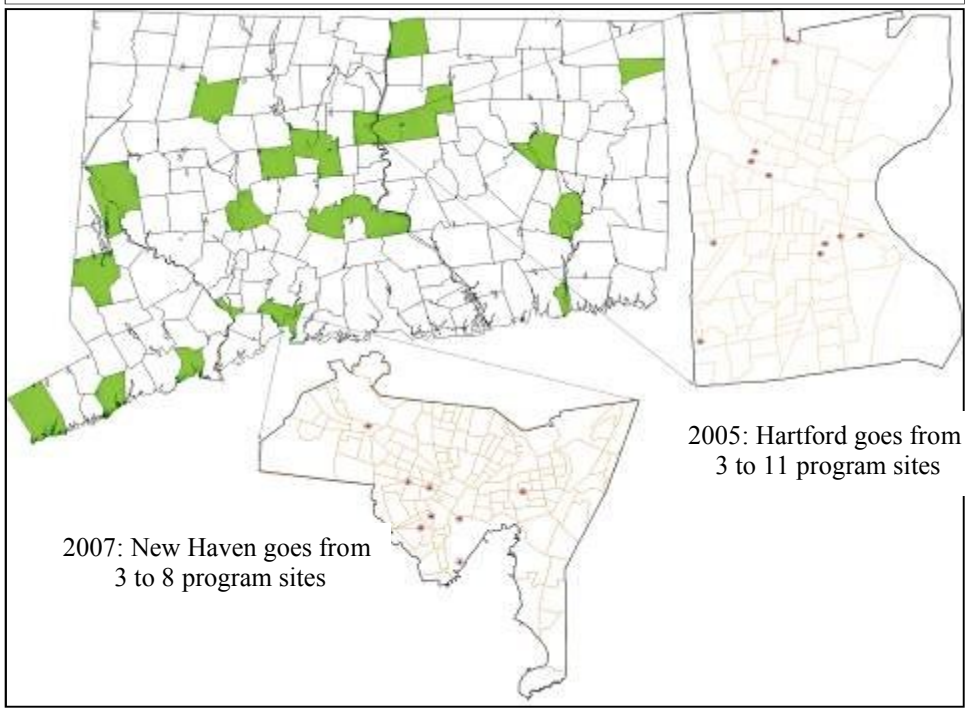
Hartford NFN

Similar to statewide data, in this section we will report on enrollment, descriptive, and outcome data for families participating in home visitation within Hartford NFN.

New Haven NFN

New Haven NFN initiated screening and intake in October of 2007, thus, only preliminary data will be presented on data collected from October-December of 2007. However, in order to gain an understanding of the context in which the New Haven NFN program is providing services, we report on regional and neighborhood statistical information comparable to a similar analysis of Hartford in prior reports (see 2006 Annual Outcome Report). In addition, we give a brief description of each of the program sites and describe the measures that will be used to assess program outcomes.

Figure 11. Enhanced Program Services in Hartford and New Haven



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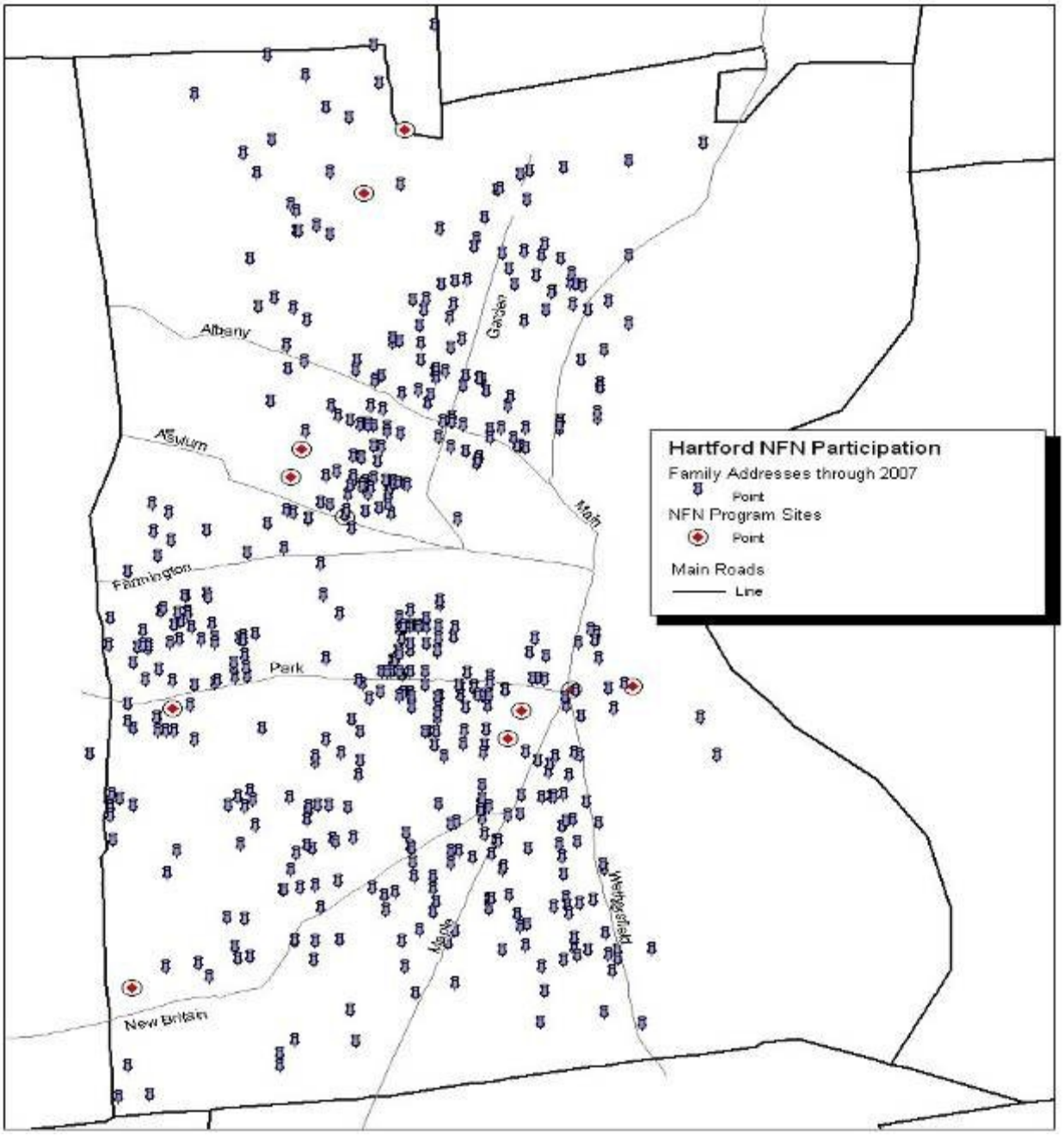
Residences of Families Who Have Received Hartford Home Visitation Services

In figure 12 there is a total of 626 addresses of families who either participated in Hartford NFN in the past or who are currently receiving services. There is an additional 18 residences within greater Hartford who also participated in Hartford NFN. Addresses are spread fairly evenly across the residential areas of the city; however, there are dense concentrations in Asylum Hill, Frog Hollow and the West End, smaller clusters of NFN families in Clay Arsenal and Upper Albany, and a large number of NFN families who are spread throughout the Northeast neighborhood.

Figure 12. NFN Program Sites and Families



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High Risk Families and Enrollment in Home Visitation Hartford Data, 2007

Disposition of Positive Screens

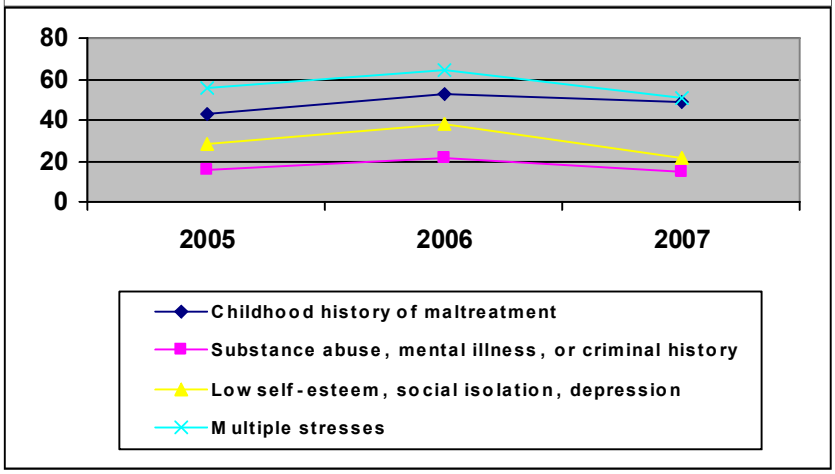
In 2007, there were 1,796 initial screens completed in Hartford and 564 (or 31%) of these first-time mothers were identified as high risk for poor parenting. As noted, in 2007 the Kempe Family Stress Checklist has been eliminated as part of the eligibility requirement but is still administered to obtain more in-depth information on families histories and risk factors.

Services are offered based on program capacity; as compared with previous two years, Table 23 shows that the percentage of families offered services has declined: 73% in 2007, 91% in 2006, and 98% in 2005. As a result, there were slightly less families who initiated services in 2007, 194 versus 221 in 2006.

Table 23. Disposition of Families Identified as High Risk, Hartford Data, 2005-2007

Families Identified as High Risk	2005 (N=526)	2006 (N=1164)	2007 (N=1796)
# of Positive Screens	300	548	564
Offered Kempe Offered Home visiting (in 2007)	295 (98%) ——	505 (92%) ——	—— 412 (73%)
Accepted Kempe Accepted home visiting (in 2007)	188 (64%) ——	288 (57%) ——	—— 222 (54%)
Completed Kempe	169 (90%)	234 (81%)	215 (97%)
Initiated services	155 (92%)	221 (94%)	194 (90%)

Fig 13. Rates of Hartford NFN Mothers Scoring at Severe Risk as Measured by the Kempe Family Stress Checklist, 2005-2007



Mothers' Scores on Kempe Items

- As described in Table 24, approximately one-half of mothers scored at severe risk on the Childhood History of Abuse/Neglect subscale (49%) and on the Multiple Stresses (51%). Approximately one-half of first time mothers scored at the moderate to severe risk on History of Crime, Substance Abuse, Mental Illness subscale and 91% scored at the moderate to severe risk on the Low Self-Esteem/Social Isolation/ Depression subscale.
- As Figure 13 depicts, these scores were slightly higher in 2006, but similar to scores in 2005 and indicate that these families are at high risk.

Table 24. Hartford Mothers' Kempe Scores, 2007	0	5	10
1. Childhood History of Abuse/Neglect (N=202)	32%	19%	49%
2. History of Crime, Substance Abuse, Mental Illness (N=201)	53%	31%	15%
3. CPS History (N=201)	93%	3%	4%
4. Low Self-esteem/ Social Isolation/ Depression (N=201)	9%	69%	21%
5. Multiple Stresses (N=202)	10%	40%	51%
6. Potential for Violence (N=202)	79%	8%	13%
7. Unrealistic Expectation of Child (N=202)	58%	35%	7%
8. Harsh Punishment (N=201)	81%	13%	6%
9. Negative Perception of Child (N=199)	87%	11%	2%
10. Child Unwanted/ Poor Bonding (N=202)	9%	81%	9%

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Risk Profiles: Hartford Mothers' Kempe Scores, 2005-2007

2007 Hartford Mothers' Kempe Scores on Individual Items

The Kempe is scored across 10 items, with each item scored either 0 (no/low risk), 5 (moderate risk), or 10 (severe risk), to indicate presence and severity. Each of these items, however, includes a larger set of criteria from which judgments are made, and these criteria provide a much better description of risk. As part of our enhanced research design in Hartford, we report on these data for families who scored in the severe range focusing on items with the highest rates of severe risk:

- *Item 1: Childhood History of Abuse/Neglect (N=202)*
  Forty-nine percent, 99 of these mothers, were identified as experiencing severe forms of abuse or neglect as children. Of these 99 mothers, 37% experienced severe beatings and 43% were raised by parents who were alcoholics or drug addicted; 35% were raised by *more* than 2 families and 30% were removed from their home or abandoned by their parents.
- *Item 4: Low Self-esteem/Social Isolation/ Depression (N=201)*
  Twenty-one percent (42 mothers) scored at severe risk on this multiple construct item. More than half of these mothers reported that they were socially isolated (rarely saw other people and when they did, they did not find it enjoyable; 50% reported that they had a history of child maltreatment without resolution; 41% had a history indicative of limited coping; 35% reported feeling very unhappy or depressed with life; 30% indicated they were not close to their family; and 24% could not name any lifelines.
- *Item 5: Multiple Stresses (N=202)*
  Fifty-one percent, 103 of 202 mothers, indicated severe levels of multiple stresses. Twenty-three percent of these mothers reported being in constant conflict and 20% experienced continual crises which they felt unable to handle; 78% reported that financial difficulties were related to much of their stress.

Comparison of Kempe Scores: Program years 2005-2007

As with the statewide data, Table 25 shows that in comparison with 2005 and 2006, there is a significant increase in the percentage of families scoring at Low Risk on the Kempe (i.e., 20 or below).

Table 25. Hartford Mothers' Kempe Scores, 2005-2007

Kempe Scores	2005 N=153	2006 N=217	2007 N=201
Low-risk (0-20)	9%	3%	24%
Moderate risk (25-25)	55%	54%	38%
High-risk (40-60)	32%	39%	35%
Severe risk (65-100)	5%	4%	3%
Mean	37	38	33

Mothers who Scored at Low Risk on Kempe

Inspection of REID screens for mothers who scored at Low Risk on the Kempe showed that

- 82% were single, separated or divorced,
- 80% had inadequate income (or had no information)
- 39% had less than a HS education
- 36% were teenage mothers
- 29% had marital or family problems, and
- 20% had a history of or current depression.

Although the change in eligibility screening has allowed more mothers to enroll who do not meet the cutoff point on the Kempe (i.e., a score of 20 or below), these are still vulnerable mothers/families who are at high risk for poor parenting.

Also, as shown in Table 26, mothers' scores at program entry on the CAPI-Rigidity subscale were comparable across the two groups; interestingly for both groups these scores are low in comparison with statewide data and Hartford data in prior yrs.

Table 26. CAPI Rigidity Scores by Kempe Risk Profiles Hartford Data, 2007

Rigidity Subscale	Low Risk Score 0-20	High Risk Score 25+
Rigidity	19.8	20.1

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Home Visitation Families at Program Entry
Hartford Data, 2007

Health Related Risk Factors

Health data provided in Table 27 indicate that:

- 12% of NFN children were born with serious medical problems, 10% were born premature and 11% with low birth weight.

Rate of premature births in 2007 is comparable to the state rate of 10.1% (*National Vital Statistics Report*, 2003) while rate of children born with low birth weight is higher than the state rate of 7.4%, and national rate of 7.7% (*Kids Count Data Book*, Casey Foundation, 2004).

Table 27. Pregnancy & Birth Information, Hartford Data, 2005-2006

Health Related Risk Factors	2005 N=108	2006 N=124	2007 N=127
Mother smoked cigarettes during pregnancy	8%	4%	4%
Mother drank alcohol during pregnancy	1%	3%	0%
Mother used illicit drugs during pregnancy	4%	5%	2%
Child born with serious medical problems	13%	6%	12%
Premature Birth (before 37 weeks gestation)	7%	15%	10%
Born Low Birth Weight (under 5 lbs 8 oz)	5%	17%	11%
Child has a Pediatrician			
Yes	98%	98%	97%
No	0%	2%	1%
Unknown	2%	0%	2%

Table 28. Household Information, Hartford Data, 2007

Prenatal Screens (N=192)	40%
Mother's Marital Status (N=197)	
Single, never married	94%
Married	5%
Divorced, separated, widow	1%
Mother's Race/Ethnicity (N=198)	
White	5%
African American	29%
Hispanic	56%
Other (includes multi-racial)	10%
Mother age at Baby's Birth (N=132)	
Under 16 years	8%
16-19 years	41%
20-22 years	24%
23-25 years	14%
26 years and older	14%
Median Age	20 yrs
Maternal Grandmother Living in the Household (N=196)	45%
Father Living in the Household (N=196)	33%
Father's Involvement W/ Child (N=116)	
Very involved	54%
Somewhat involved	18%
Sees child occasionally	5%
Very rarely involved	2%
Does not see baby at all	21%

Family and Household Data

Hartford mothers were similar to profiles of mothers statewide with the exception that all but 5% were nonwhite (see Table 28).

- 94% of Hartford NFN mothers were single/never married (versus 89% statewide)
- Median age at child's birth was 20 yrs.
- Unlike the statewide population where close to 2/3 of fathers were living in the house and 21% of mothers were living with maternal grandmother, only 1/3 of the fathers were living in Hartford NFN households and 45% of the mothers were living with the maternal grandmother.

Financial and Social Risk Factors

- As shown in Table 29, home visitors considered 67% of these mothers to have financial difficulties at time of program entry (similar to 66% statewide).
- Home visitors perceived 19% of Hartford mothers to be socially isolated, compared with 30% statewide. However, Table 30 shows that 51% of mothers' self-ratings on the Center for the Epidemiological Studies scale (CES-D) indicate they were experiencing significant level of depression.

Table 29. Hartford Mothers' Social Isolation, Arrest Histories & Financial Difficulties

Socially isolated (N=187)	19%
Arrest history (N=183)	12%
Financial difficulties (N=185)	67%
Receiving TANF (N=180)	9%
Receiving Food Stamps (N=180)	24%

Table 30. % of Mothers Scoring Above the Cutoff on the CES-D (N=454)

Mean CES-D Depression Score	% Scoring Above Cutoff
16.7	**51%**

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Education and Employment Rates at Program Entry
Hartford Data, 2007

Hartford NFN 2007:
Mothers' Life Course Information

Mothers' education and employment data are presented in Table 31, separating mothers who were 19 years or younger when they had their child from those who were 20 and older.

- Seventy-nine percent of the younger cohort of mothers had less than a high school education at program entry; however, 41% were enrolled in school. In comparison with the statewide population, the older Hartford cohort had a higher level of education overall: 15% had less than a high school degree versus 24% statewide; 54% had some post secondary education versus 38% among the statewide population.
- Rates of employment for Hartford mothers were somewhat similar to statewide population; however; 32% of the younger group and 76% of the older cohort were employed prior to pregnancy and 21% and 22%, respectively, were employed at time of enrollment.

Table 31.
Mothers' Life Course, Hartford Data, 2007

Mother Life Course Indicators	19 and younger	20 and older
Education	(N=63)	(N=67)
Eighth grade or less	3%	3%
More than 8th grade, < high school	76%	12%
High school degree or GED	13%	31%
Some vocational training/college	6%	45%
College degree or graduate work	2%	9%
Enrolled in School	(N=63)	(N=68)
Yes	41%	13%
Employment Status	(N=63)	(N=68)
Mother not employed	79%	78%
Mother employed	21%	22%
Full-time	3%	13%
Part-time job or occasional work	17%	9%
Employed Prior to Pregnancy	(N=60)	(N=66)
Yes	32%	76%

Hartford NFN 2007
Fathers' Life Course Information

As with mothers' data, we analyzed employment and educational data by father's age at baby's birth. All data on fathers should be interpreted with caution; home visitors often rely on mothers to provide information, as already noted. Also, the data in Table 32 is based on a very small sample size and may not be representative of all the fathers.

- For the younger cohort, 40% of the fathers had less than a high school education (vs. 60% among fathers statewide) and 50% were enrolled in school; 16% of the older cohort had less than a High School education (vs. 21% for statewide population) and 25% had at least some post secondary education (similar, in this instance, to 29% among statewide fathers).
- Sixty percent of the younger group and 34% older Hartford cohorts were unemployed. Among the state population these rates were 47% and 28%.
- Fathers were incarcerated at higher rates in Hartford: 21% of the younger cohort and 18% of the older in comparison with 11% and 4% for statewide, respectively.

Table 32.
Fathers' Life Course, Hartford Data, 2007

Father Life Course Indicators	19 and younger	20 and older
Education	(N=16)	(N=44)
Eighth grade or less	6%	2%
More than 8th grade, < high school	31%	14%
High school degree or GED	56%	59%
Some vocational training/college	6%	14%
College degree or graduate work	0%	11%
Enrolled in School	(N=14)	(N=46)
Yes	50%	2%
Employment Status	(N=15)	(N=47)
Father not employed	60%	34%
Father employed	40%	66%
Full-time	20%	40%
Part-time job, occasional work, Or working more than one job	20%	26%
Fathers With an Arrest History	(N=15)	(N=40)
Yes	47%	35%
Currently Incarcerated	(N=19)	(N=44)
Yes	21%	18%

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Home Visitation Participation, Hartford Data, 2007

Table 33.
Hartford Program Participation, 2005 - 2007

Frequency of Home Visits	2005 N=104	2006 N=313	2007 N=420
Average # of attempted home visits	3.1	2.9	3.2
Average # of completed home visits	2.1	1.9	2.1
Average # of office/out of home visits	0.2	0.2	0.2
Average # of NFN social events attended	0.1	0.2	0.1
Total # of visits completed	2.4	2.3	2.4

As of the end of 2007, there were 383 families who were active at the Hartford program sites.

Figure 14.
6 month, 1 year, and 2 year Program Retention Rates
Hartford compared with Statewide Data

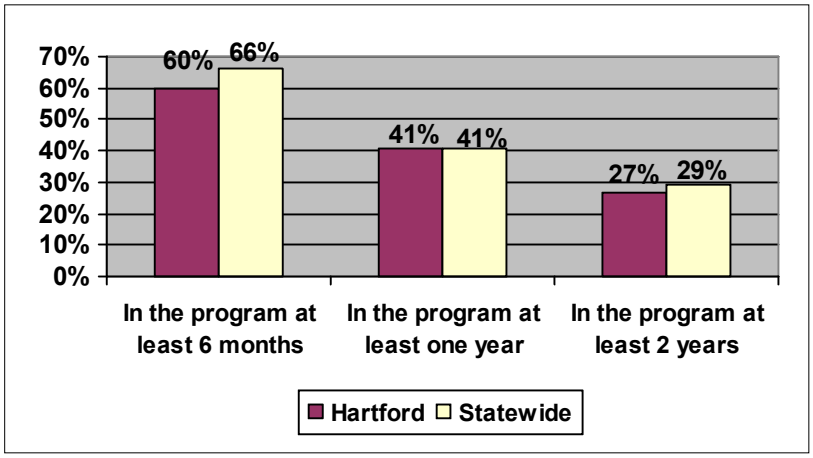

Table 34.
Reasons Hartford Families Leave Home Visiting, 2005 - 2007

Reasons Hartford Families Left the Program	2005 N=29	2006 N=159	2007 N=157
Family moved out of service area	24%	18%	15%
Unable to locate mother	17%	31%	37%
Discharged, family was noncompliant	0%	0%	0%
Family decided to discontinue services	45%	23%	21%
Mother is working or in school full-time, no time for home visits	3%	20%	21%
Goals were met/family graduated	0%	0%	0%
Baby removed from home by DCF	0%	1%	1%
Discharged, family was not appropriate for the program	0%	0%	1%
Other family member did not approve of services	0%	1%	2%
Home visitor left the program	0%	0%	0%
Other	10%	6%	4%

Participation Rates

- Similar to the statewide population, families, on average, receive 2 visits per month (see Table 33). However, the average number of attempted visits have been consistently higher in Hartford than statewide for the past 3 years: average number of attempted visits have been 3.1, 2.9, and 3.2 for 2005, 2006, 2007 program years respectively versus 2.0, 2.7, and 2.9 statewide. As already noted, for the statewide data, an increase in attempted visits paralleled an increase in completed visits: from 1.4 in 2005 to 2.1 in 2007.

Program Retention Rates

- Six month, one year, and two year retention rates for Hartford and Statewide (without Hartford) are shown in Fig. 14. Six month retention rates are higher for the statewide population—66% versus 60% for Hartford sites, but 1 and 2 year retention rates are similar between Hartford and the statewide sites.

Reasons Families Leave the Program

- Similar to statewide data, the foremost reason families stop participating is because the families are unable to be located (without informing staff). As compared with statewide data, families decide to leave the program (for unspecified reasons) at higher rates in Hartford (21% vs. 15% statewide), and the percentage of mothers who are unavailable for services due to work and school schedules are also higher in Hartford (21% vs. 15%). Also, 15% of families who discontinued services moved out of the service area.

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Utilization of Community Resources
Hartford Parent Outcomes, 2007

Community Referrals

Community referrals are documented in Hartford where there are high poverty rates to assess service networks that NFN home visitation is part of.

- As shown in Table 35, home visitors made 911 referrals on behalf of families, mostly for housing (21%) and employment/education (18%) needs, and families followed through with about two-thirds of these referrals. These data are very similar to last year's data. (also see focus group data in this report on community referrals and outcomes).

Table 35.
Number and Type of Community Referrals, Hartford Data, 2007

Type of Referrals 2007 (N=420)	#	%	Follow-Up Rate
WIC	15	2%	67%
DSS	74	8%	73%
Social Security	4	<1%	50%
Food needs	77	8%	78%
Doctor/medical services	59	6%	85%
Housing needs	194	21%	78%
Legal needs	12	1%	75%
Household needs	41	5%	90%
Early intervention/day care	62	7%	66%
Mental health/counseling	38	4%	53%
Crisis intervention	10	1%	90%
Parenting class/program	30	3%	20%
Domestic violence	7	1%	14%
Substance abuse	1	<1%	0%
Employment/education	166	18%	55%
Dept of Children & Families	4	<1%	75%
Recreation	2	<1%	100%
Cultural/religious	1	<1%	100%
Other	111	12%	47%
TOTAL	911	100%	66%

Table 36. Change in Mean Scores on the Community Life Skills Scale 6 mo, 1 and 2 Yr Participants, Hartford, 2007

Community Life Skills	Entry (N=227)	6 Mo
Total	23.1	24.5***
Transportation	3.2	3.4**
Budgeting	2.8	3.2***
Support services	4.1	4.4***
Support/Involvement	4.0	4.5**
Interests/Hobbies	2.6	2.6
Regularity/Organization/ Routines	6.4	6.5

Community Life Skills	Entry (N=101)	6 Mo	1 Yr
Total	23.1	24.6	25.7***
Transportation	3.3	3.4	4.2
Budgeting	2.9	3.2	3.5***
Support services	4.1	4.4	4.6***
Support/Involvement	4.1	4.6	4.7**
Interests/Hobbies	2.6	2.6	2.8
Regularity/Organization/ Routines	6.3	6.3	6.5

Community Life Skills	Entry (N=28)	6 Mo	1 Yr	2 Yr
Total	23.2	24.8	25.7	25.6*
Transportation	3.3	3.4	3.4	3.5
Budgeting	2.9	3.3	3.8	4.0*
Support services	4.0	4.5	4.5	4.5*
Support/Involvement	3.9	4.5	4.7	4.9*
Interests/Hobbies	2.6	2.4	2.7	2.6
Regularity/Organization/ Routines	6.4	6.8	6.5	6.0*

*p<.05 **p<.01 ***p<.001

Community Life Skills Scale (CLS)

Data on the Total CLS scale, and each of the subscales were analyzed separately (in a repeated measure analysis of variance) for mothers active for 6 months (N=227), 1 yr. (N=101) and two years (N=28).

- Table 36 shows that statistically significant changes in mean scores were documented on the Total CLS scale and several subscales. There was improvement in the areas of budgeting and accessing support services as well as improvement on the Support/Involvement scale suggesting mothers have more supportive relationships during the time spent in the program.

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Change in Parenting Attitude and Change in Mental Health Hartford Outcomes, 2007

Center for the Epidemiological Studies Depression Scale (CES-D): Hartford Outcomes

The CES-D is used to assess the prevalence of depression in the Hartford sample. It is a widely used self-report scale intended for the general population. The instrument measures depressed mood, feelings of guilt and worthlessness, feelings of helplessness and hopelessness, loss of appetite, sleep disturbances, and psychomotor retardation. Data for the CES-D were analyzed separately (in a repeated measures analysis of variance) for mothers active for six months (N=194), one year (N=84), and two years (N=20) as of the end of the 2007 program year.

Table 37. Depression Scale Outcomes 6 Month , 1 and 2Year Data

6 mo CES-D (N=194)	Program Entry	6 Months
Depression score	18.8	14.2***

1 yr CES-D (N=84)	Program Entry	6 Months	1 Year
Depression score	19.0	14.1	14.2***

CES-D Scores (N=20)	Program Entry	6 Months	1 Year	2 Year
Depression score	17.8	14.0	14.5	13.8

*p<.05 **p<.01 ***p<.001

- As shown in Table 37, the mean scores on the CES-D at program entry for each year, 2005, 2006, and 2007 were above the cut-off point of 16, indicating that mothers were experiencing depressed mood.
- Data presented in Table 37 shows mothers' average scores not only significantly decreased for each of the analyses, but *actually decreased to below the cut-off point of 16 even when mothers were active for only six months.* This is an interesting finding given that maternal depression is known to present challenges for home visitation.
- For last year's Hartford sample, there was no change in 6 month and 1 year data .

Child Abuse Potential Inventory, Rigidity Subscale (CAPI-R): Hartford Outcome Data

In Table 38, we present outcome data on the Child Abuse Potential Inventory Rigidity Scale (CAPI-R), a self-report scale that measures the rigidity of attitudes and beliefs about the appearance and behavior of children. The subscale is based on the theoretical assumption that rigid attitudes and beliefs lead to a greater probability of child abuse and neglect. Hartford parents complete the CAPI-R at program entry, six months, and then on annual anniversaries of their start-date in the program.

Table 38. Child Abuse Potential Inventory - Rigidity Subscale Hartford Outcome Data, 6 Month, 1 and 2 Year Participants

6 mo CAPI (N=207)	Program Entry	6 Months
Mean Rigidity Score	31.2	26.6***

1 yr CAPI (N=101)	Program Entry	6 Months	1 Year
Mean Rigidity Score	32.0	27.1	27.3**

2 yr CAPI (N=28)	Program Entry	6 Months	1 Year	2 Year
Mean Rigidity Score	36.1	25.8	26.9	20.7***

*p<.05 **p<.01 ***p<.001

- Data for the CAPI-R were analyzed separately (in a repeated measures analysis of variance) for mothers active for six months (N=207), one year (N=101), and two years (N=28) as of the end of the 2007 program year.
- *Results indicate that mothers significantly reduced their risk for maltreatment even when active in the program for only six months.* These data indicate that mothers have less rigid expectations of their children and are less likely to treat them forcefully.

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2007 Hartford Data Analysis: Summary of Key Findings

Program Capacity and Enrollment of High Risk Families

- In 2007, there were 1,796 initial screens completed in Hartford and 564 (or 31%) of these first-time mothers were identified as high risk for poor parenting;194 Hartford families initiated services in 2007.
- The percentage of Hartford families who are offered home visitation services has declined from 98% in 2005, and 91% in 2006 to 73% in 2007, indicating that many of the Hartford NFN programs are becoming filled to capacity since first going to scale in 2005.

Risk Profiles

- Similar to the statewide data, in comparison with 2005 and 2006, there was a significant increase in the percentage of families scoring at Low Risk on the Kempe Family Stress Checklist for the Hartford families (i.e., 24% received a score of 20 or below). However, inspection of REID screens for first-time mothers who scored at Low Risk on the Kempe showed that 82% were single, separated or divorced; 80% had inadequate income (or had no information); 39% had less than a HS education; 36% were teenage mothers; 29% had marital or family problems; and 20% had a history of or current depression. Although the change in eligibility screening has apparently allowed more mothers to enroll who do not meet the cutoff point on the Kempe (i.e., a score of 20 or below), these are still vulnerable mothers/ families who are at high risk for poor parenting.

Hartford NFN Program Outcomes

- Hartford mothers showed a statistically significant change in their self-reports of depression as measured by the CES-Depression scale. Average scores not only significantly decreased for each of the analyses (mothers participating at 6 months, 1 year and 2 years) but actually decreased to below the cut-off point of 16 even when mothers were active for only six months.
- Similarly, mothers significantly reduced their risk for maltreatment as measured by the CAPI-Rigidity subscale at 6 months, 1 year, and 2 years participation time. This was true even when active in the program for only six months. These data indicate that mothers have less rigid expectations of their children and are less likely to treat them forcefully.

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Regional and Neighborhood Contexts of New Haven NFN
by Kevin Lamkins

New Haven NFN

In 2007, New Haven became the second city in Connecticut to go to scale within the NFN program. In addition to Hartford, New Haven now screens all first-time mothers for home visitation services. New Haven has 8 sites throughout the city.

Like Hartford, New Haven has a high concentration of parents living in poverty, and all the related challenges. Also similar to Hartford, greater New Haven suffers from extreme regional inequality. As the program has expanded within New Haven, this report will analyze regional and neighborhood statistical information comparable to analysis of Hartford in past reports (see *Nurturing Families Network: 2006 Annual Evaluation* Report)

Regional Inequality

The 21 towns surveyed in the New Haven area present stark inequality and segregation along racial, ethnic and social class lines. These data are shown in Table 39 and are mapped in Figure 13.

- Data from the 2000 US Census show a variety of disparities between New Haven and its inner and outer ring suburbs. At that time, there were 600,322 people living in these towns. New Haven housed 123,626 people, or almost 21% (20.6%) of the total region's population.
- Table 39 shows median family income across the 21 towns making up the New Haven area. The wealthiest towns, those with median family incomes greater than $85,000, are Woodbridge, Cheshire, Orange, and Guilford. New Haven is the poorest city in the area by far. In fact it's the only town in the group that has a median family income of less than $50,000.
- The average median family income across the towns in the region is $73,540. West Haven has the second lowest of the region, representing ~ 70% of the average, but at $35,950, New Haven's average median family income is only 49% of the regional average.

Table 39. Median Family Income by Town in Region

Town:	**Median Family Income:**	**% of Regional Average:**
Ansonia	$53,718	73.0%
Beacon Falls	$62,461	84.9%
Bethany	$79,493	108.1%
Branford	$69,510	94.5%
Cheshire	$90,774	123.4%
Derby	$54,715	74.4%
East Haven	$56,803	77.2%
Guilford	$87,045	118.4%
Hamden	$65,301	88.8%
Milford	$71,226	96.9%
Naugatuck	$59,216	80.5%
New Haven	$35,950	48.9%
North Branford	$71,813	97.7%
North Haven	$73,041	99.3%
Orange	$88,583	120.5%
Oxford	$80,422	109.4%
Prospect	$74,038	100.7%
Seymour	$65,012	88.4%
Wallingford	$68,327	92.9%
West Haven	$51,631	70.2%
Woodbridge	$111,729	151.9%
Median Family Income Regional Average: $73,540		

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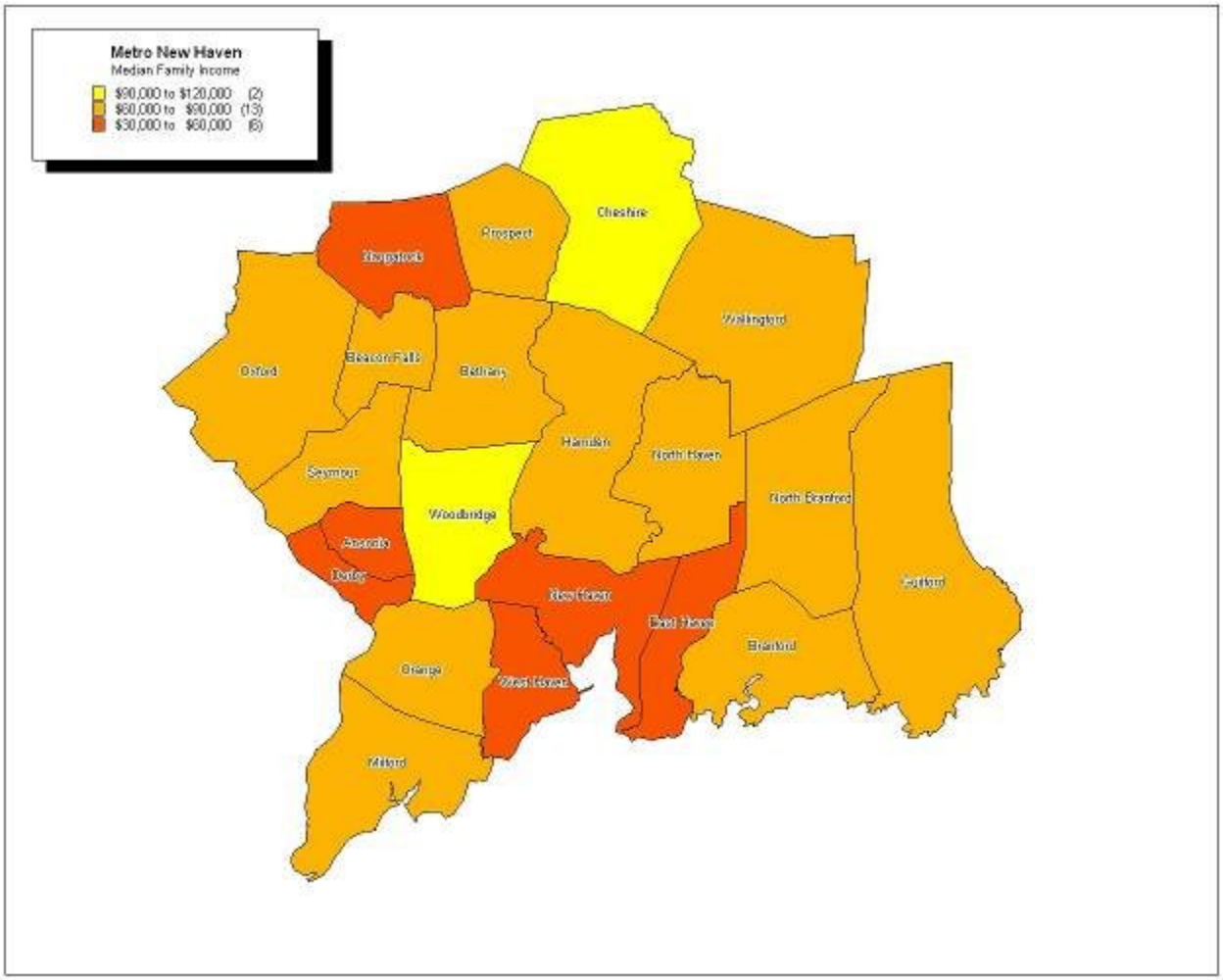
Regional and Neighborhood Contexts of New Haven NFN

Figure 15 shows median family income for each of the 21 towns in the New Haven region.

- The median family income for two towns between $90,00 and $120,000: Cheshire and Woodbridge.
- The median family income for thirteen towns is between $60,000 and $90,000: Beacon Falls, Bethany, Branford, Guilford, Hamden, North Branford, North Haven, Milford, Orange, Oxford, Prospect, Seymour, and Wallingford.
- The median family income for six towns is between $30,000 and 60,000: Ansonia, Derby, East Haven, Naugatuck, New Haven, and West Haven.
- At $35,950, New Haven's average median family income is only 49% of the regional average, $73,540.

Figure 15. Median Family Income by Town in Region
21 Towns in New Haven Area, 2007



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Median Family Income by Town by Race/Ethnicity
New Haven NFN

Adding race and ethnicity to income data demonstrates even greater complexity, as shown in Table 40.

- Unlike what we found in the Hartford area data, non-whites in the wealthier areas do not necessarily have higher incomes. For instance, in Cheshire, median family income for blacks is just $29,750, compared to $85,232 for Asians, $94,615 for Hispanics, and $90,829 for whites.
- It is difficult to draw conclusions from these data because many of the towns have so few non-white residents. Nine of the towns have fewer than 200 black residents, while seven towns have fewer than 200 Hispanic residents.

Table 40. Median Family Income by Town by Race/Ethnicity

Town:	Black Family Median Income	Asian Family Median Income	Hispanic Median Income	White Family Median Income
Ansonia	$27,232	$56,923	$34,688	$55,997
Beacon Falls	$127,308	$85,118	$0	$62,031
Bethany	$42,031	$78,750	$80,000	$80,218
Branford	$92,216	$76,278	$48,828	$70,333
Cheshire	$29,750	$85,232	$94,615	$90,829
Derby	$38,750	$60,341	$40,286	$56,266
East Haven	$58,839	$49,286	$53,906	$57,023
Guilford	$72,841	$102,837	$74,792	$86,986
Hamden	$56,138	$63,906	$48,000	$69,905
Milford	$82,416	$70,263	$69,348	$71,223
Naugatuck	$51,029	$69,821	$41,875	$59,454
New Haven	$31,198	$42,500	$24,594	$52,482
North Branford	$29,792	$85,176	$75,421	$71,703
North Haven	$98,556	$66,563	$90,370	$72,445
Orange	$61,875	$98,160	$122,677	$89,306
Oxford	$172,575	$71,250	$100,778	$79,860
Prospect	$86,707	$36,250	$85,000	$74,375
Seymour	$90,426	$66,389	$46,193	$65,500
Wallingford	$81,343	$64,271	$49,052	$69,359
West Haven	$43,766	$52,604	$35,208	$55,937
Woodbridge	$80,348	$126,993	$94,868	$112,575

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Income Earnings by Gender and Town, New Haven NFN

Patterns of earnings by gender are illustrated in Table 41.

- By far, New Haven has the highest percentage of males who earn less than $25,000 per year. At 54.5%, New Haven is nearly 20 percentage points higher than the next closest town, West Haven, for which 34.6% of males earn less than $25,000 per year. New Haven's rate is also more than double that of 12 of the 21 towns. Only four towns in the region have a 30% or higher rate of male earners below that threshold.
- Nearly 65% of female earners in New Haven make less than $25,000 per year. Interestingly, the wealthier towns tend to have a greater disparity between males and females who earn less than $25,000 per year. More than a third of the towns in the region (8 out of 21) have rates above 50% for female earners in this range, with just two, New Haven and Ansonia over 60%.
- More than one third (33.9%) of all male earners in Woodbridge earn more than $100,000 per year. Few women in the region make over $100,000 per year.

Table 41. Income Earnings by Gender and Town, 16 Years and Older

	Male				Female			
Town:	**< $25,000**		**> $100,000**		**< $25,000**		**> $100,000**	
Ansonia	1548	30.1%	98	1.9%	3107	61.5%	16	0.3%
Beacon Falls	339	20.9%	65	4.0%	728	48.4%	11	0.7%
Bethany	432	28.3%	149	9.8%	571	40.8%	58	4.1%
Branford	2251	26.2%	902	10.5%	3580	42.1%	156	1.8%
Cheshire	2392	27.5%	1405	16.2%	2857	41.3%	165	2.4%
Derby	1052	29.8%	143	4.1%	1800	51.0%	28	0.8%
East Haven	2223	27.4%	190	2.3%	4101	52.6%	46	0.6%
Guilford	1459	21.9%	1232	18.5%	2701	44.2%	199	3.3%
Hamden	5365	34.2%	1139	7.3%	8808	51.7%	268	1.6%
Milford	3817	24.1%	1127	7.1%	6516	43.4%	229	1.5%
Naugatuck	2576	28.3%	265	2.9%	4303	52.5%	89	1.1%
New Haven	17026	54.5%	831	2.7%	21376	64.7%	354	1.1%
No. Branford	1006	24.1%	338	8.1%	2045	50.6%	33	0.8%
North Haven	1740	26.6%	550	8.4%	2877	46.1%	79	1.3%
Orange	884	23.0%	655	17.0%	1377	42.8%	125	3.9%
Oxford	710	23.0%	252	8.2%	1260	45.0%	27	1.0%
Prospect	684	25.4%	197	7.3%	1047	44.1%	17	0.7%
Seymour	1212	25.4%	179	3.7%	2161	49.9%	18	0.4%
Wallingford	3242	25.2%	771	6.0%	5791	49.1%	123	1.0%
West Haven	5186	34.6%	384	2.6%	8097	54.6%	78	0.5%
Woodbridge	538	20.0%	912	33.9%	930	43.9%	106	5.0%

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Poverty Rates by Town, New Haven NFN

Table 42 shows poverty rates by town in the region. These data are also mapped in Figure 14 (p. 36).

- Because poverty thresholds are not regionally adjusted to accommodate New England's high cost of living, deprivation and need are likely under-reported in poverty data. The following were the poverty levels in 2000, measured by income per year by family/household size:

  Family/household of 2: $11,250
  Family/household of 3: $14,150
  Family/household of 4: $17,050
  Family/household of 5: $19,950

  Poverty data are broken down into three levels: below poverty level, below 50% of poverty level, and below 200% of poverty level.
- In New Haven 24.4% of the population lives below the poverty line.
- 13% of the New Haven population makes less than 50% of the poverty level, more than 3 times the next highest rate, West Haven (4%).

Table 42. Poverty Rates by Town

Town:	**Income Below Poverty Level**		**Income Below 50% of Poverty Level**		**Income Below 200% of Poverty Level**	
Ansonia	1394	7.6%	544	2.9%	4472	24.2%
Beacon Falls	309	5.9%	142	2.7%	626	11.9%
Bethany	129	2.6%	83	1.6%	513	10.2%
Branford	1170	4.1%	433	1.5%	3824	13.5%
Cheshire	750	3.0%	450	1.8%	1841	7.2%
Derby	1014	8.3%	349	2.9%	2404	19.8%
East Haven	1453	5.2%	759	2.7%	4645	16.6%
Guilford	646	3.1%	185	0.9%	1644	7.8%
Hamden	4158	7.8%	2031	3.8%	9285	17.5%
Milford	1936	3.7%	959	1.9%	5735	11.1%
Naugatuck	1977	6.4%	878	2.9%	5483	17.8%
New Haven	27613	24.4%	14680	13.0%	52333	46.2%
North Branford	223	1.6%	182	1.3%	1562	11.3%
North Haven	799	3.5%	323	1.4%	2146	9.4%
Orange	332	2.5%	163	1.2%	946	7.2%
Oxford	206	2.1%	159	1.6%	696	7.1%
Prospect	89	1.0%	58	0.7%	435	5.1%
Seymour	573	3.7%	243	1.6%	2141	14.0%
Wallingford	1531	3.6%	711	1.7%	5381	12.8%
West Haven	4474	8.8%	2063	4.0%	12022	23.6%
Woodbridge	204	2.3%	68	0.8%	561	6.4%

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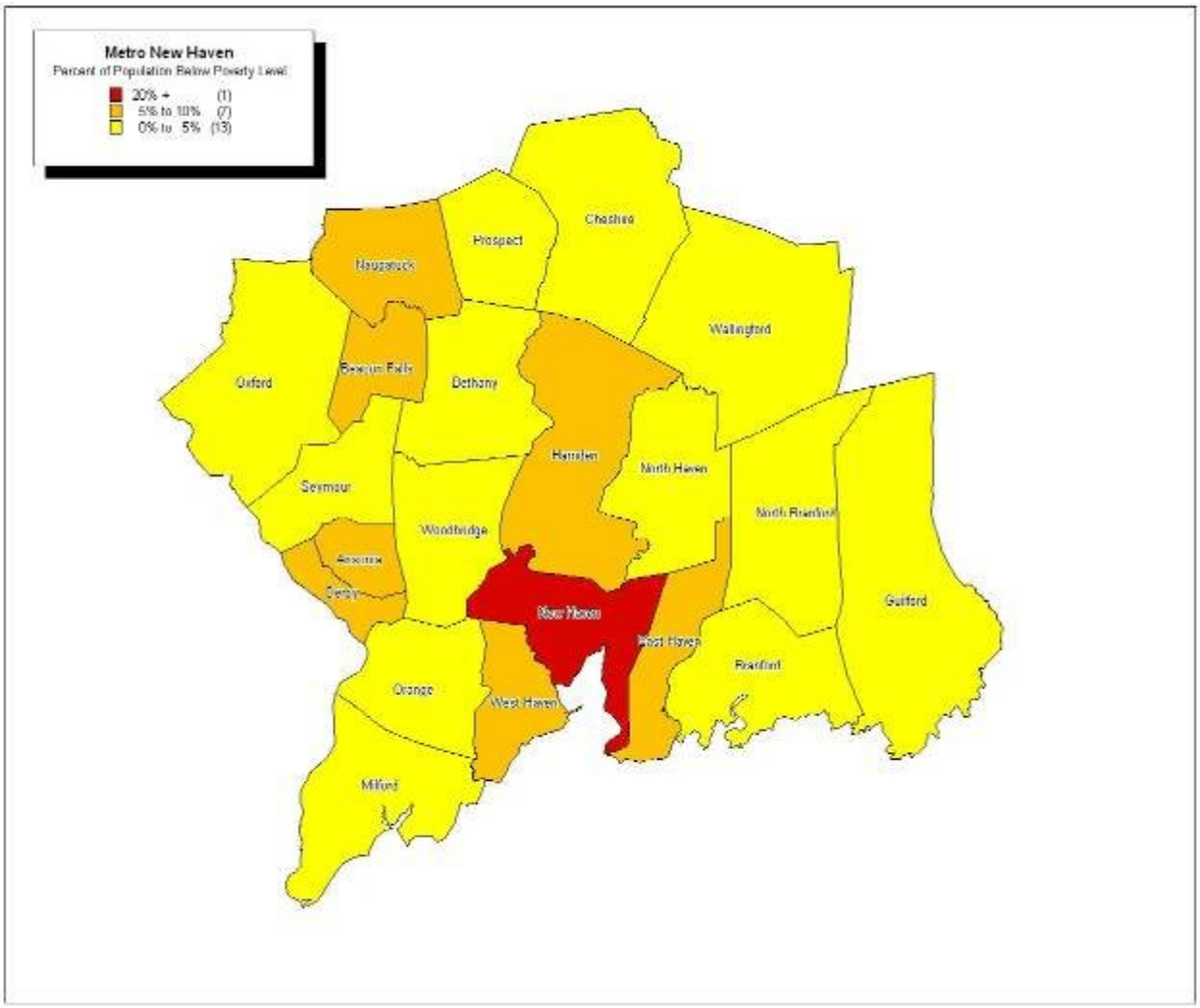
Poverty Rates by Town, New Haven NFN

Figure 16 shows poverty rates for the 21 towns in the New Haven region.

- Thirteen towns have 0-5% poverty rates: Bethany, Branford, Cheshire, Guilford, North Branford, North Haven, Milford, Orange, Oxford, Prospect, Seymour, Wallingford, and Woodbridge.
- Seven towns have 5 to 10% poverty rates: Ansonia, Beacon Falls, Derby, East Haven, Hamden, Naugatuck, and West Haven.
- New Haven, with a poverty rate of 24.4%, stands alone as having by far the highest rates of poverty in the region.

Figure 16. Poverty Rates by Town



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Percentage of Children Living with Both Parents, New Haven

The following data specifically address children. First is a comparison of young children, ages birth to five years, who live with both parents (see Table 43).

- At 40.2%, New Haven has the lowest rate of children who live with both parents. Only three towns have rates lower than 70% - Ansonia, New Haven, and West Haven. More than two thirds of towns in the region (15 out of 21) have rates above 80%.

Child Poverty and Regional Child Poverty Distribution Index

Child poverty for ages birth to five is shown in Table 44 (p. 38).

- There is a total of 5,377 children in poverty in this age range in the region. Strikingly, 62% of these children live in New Haven alone. When West Haven and Naugatuck are added, the three towns make up 77% of all poor children in the region.

To account for different town sizes, we developed a Regional Child Poverty Distribution Index (RCPDI), shown in Table 44. We first determined the distribution of all children, birth to five, living in the various towns. We then subtracted the percentage of poor children from the percentage of children living in the town. If every town shared the burden of child poverty evenly – that is, if the child poverty rate was the same as the percentage for the region's children living in the town – then the score would be zero.

Table 43. Percent of Children (0-5) Living with Both Parents Across Towns

Town:	Children 0-5 years	Living with Two Parents	
Ansonia	1436	926	64.5%
Beacon Falls	412	368	89.3%
Bethany	421	364	86.5%
Branford	1785	1482	83.0%
Cheshire	2076	1902	91.6%
Derby	917	722	78.7%
East Haven	1799	1316	73.2%
Guilford	1635	1475	90.2%
Hamden	3508	2816	80.3%
Milford	3683	2989	81.2%
Naugatuck	2553	1815	71.1%
New Haven	9882	3976	40.2%
North Branford	1052	914	86.9%
North Haven	1467	1295	88.3%
Orange	993	894	90.0%
Oxford	790	707	89.5%
Prospect	642	574	89.4%
Seymour	1116	953	85.4%
Wallingford	3231	2687	83.2%
West Haven	3991	2411	60.4%
Woodbridge	536	487	90.9%

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Regional Child Poverty Distribution Index, New Haven NFN

Towns' Share of the Burden of Housing Poor Children

The figures under RCPDI in Table 44 represent the percentage or number of poor children who need to move in or out of a town for the town to share the burden of housing poor children equally. For example:

- Cheshire would need to increase its share of the region's poor children by 3.9%, or 211 poor children.
- Milford would need to increase its share of poor children by 6.7%, or 362 poor children, to share the burden equally.
- In West Haven 0.6% or 33 poor children would have to leave to equalize its share.
- In New Haven, nearly 40% of poor children would need to relocate, or 2,125 children.

There are only 3 towns that have a positive RCPDI scores, that is, within the region, these towns have more than their share of poor children. They are Ansonia, West Haven, and, of course, New Haven. There are 18 towns that have fewer poor children than their share.

These data show vividly how child poverty is concentrated in New Haven.

Table 44. Distribution of Poor Children in New Haven Region

Town:	0-5 Years Old		RCPDI	
Ansonia	196	3.6%	0.4%	20
Beacon Falls	28	0.5%	-0.4%	-22
Bethany	9	0.2%	-0.8%	-43
Branford	86	1.6%	-2.5%	-132
Cheshire	43	0.8%	-3.9%	-211
Derby	47	0.9%	-1.2%	-65
East Haven	69	1.3%	-2.8%	-151
Guilford	82	1.5%	-2.2%	-118
Hamden	262	4.9%	-3.1%	-167
Milford	89	1.7%	-6.7%	-362
Naugatuck	286	5.3%	-0.5%	-26
New Haven	3334	62.0%	39.5%	2125
North Branford	0	0.0%	-2.4%	-129
North Haven	47	0.9%	-2.5%	-132
Orange	0	0.0%	-2.3%	-121
Oxford	5	0.1%	-1.7%	-92
Prospect	0	0.0%	-1.5%	-79
Seymour	98	1.8%	-0.7%	-39
Wallingford	168	3.1%	-4.2%	-227
West Haven	521	9.7%	0.6%	33
Woodbridge	4	0.1%	-1.1%	-62

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Block Group Data Within The City, New Haven NFN

To get a more specific understanding of the neighborhoods which house NFN families, this section of the report examines block group data. New Haven is comprised of 20 neighborhoods. Within each neighborhood there are a range of 1-17 census block groups with an average of 6.5 block groups per neighborhood. Since block groups show the diversity of socioeconomic conditions within the city they are more suitable for data analysis. Populations in the block groups range from 473 to 1,605. The average population size is 1,088. Table 47 shows the number of participating families in each neighborhood broken down by block group. So far, 27 block groups out of 129 contain NFN participating families.

Table 45. NFN Block Groups by New Haven Neighborhood

Neighborhood	# NFN Families	Neighborhood	# NFN Families	Neighborhood	# NFN Families
Amity	**5**	**Edgewood**	**0**	**Long Wharf**	**1**
12002	1			02001*	1
12003	2	**Fair Haven**	**6**		
12005	2	23001	1	**Newhallville**	**2**
		23004	1	15001	1
Annex	**1**	23005	2	15007	1
27001	1	24003	2		
				Prospect Hill	**1**
Beaver Hills	0	**Fair Haven Heights**	**0**	18004	1
				Quinnipiac Meadows	**2**
Dixwell	**3**	**Hill**	**16**	26013	2
16002	2	02001*	2		
16006	1	03002	2	**West River**	**1**
		04001	2	08004	1
Downtown	**0**	04003	2		
		05001	1	**West Rock**	**0**
Dwight	**0**	05002	2		
		06001	2	**Westville**	**1**
East Rock	**0**	06003	2	13003	1
		06004	1		
East Shore	**1**			**Wooster Sq./ Mill River**	**1**
28003	1			21001	1

* Block Group 02001 is in both Hill and Long Wharf neighborhoods, but NFN families reside only in Hill

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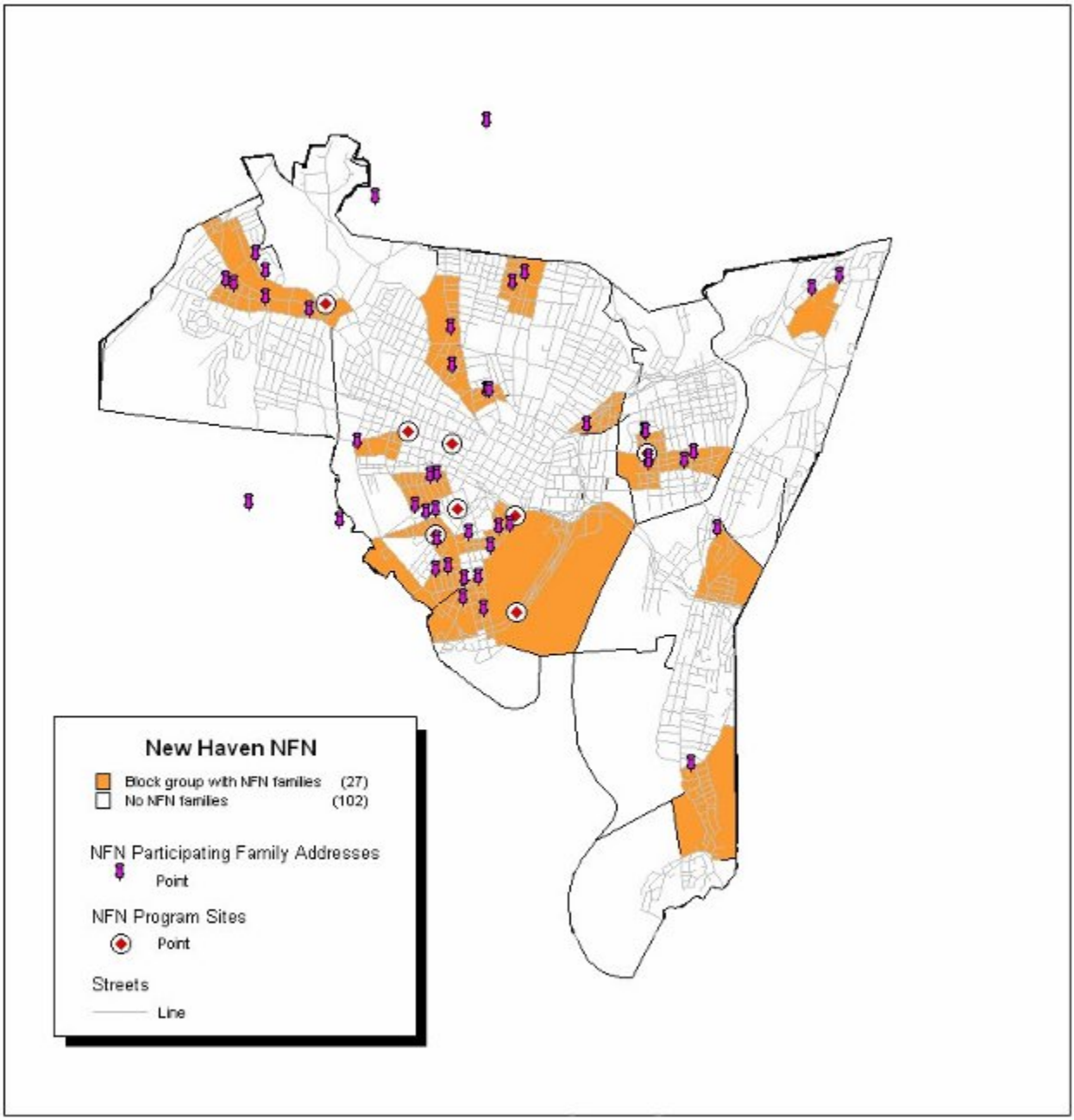
Neighborhood Block Groups Where NFN Families Reside
New Haven NFN

Figure 17 shows both the block groups and addresses for participating families. NFN families reside in 27 block groups. A total of 40 addresses fall within New Haven city limits. Seven are from surrounding towns. The highest concentration is in the south-central part of the city, in particular the Hill neighborhood which houses the most participants by far, 16.

Figure 17. New Haven NFN Families by Neighborhood and Block Group



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Median Family Income in Neighborhood Block Groups New Haven NFN

Table 46 compares median family income across the block groups and to New Haven as a whole. Median family income in New Haven is $35,950. Two block groups fall below 50 percent of the median family income in the city – one is in the Amity neighborhood, and one is in both Hill and Long Wharf.

Table 46. Median Family Income in Block Groups where NFN Families Reside		
Block Group	**Median Family Income**	**% New Haven Median Family Income**
Amity		
12002	$34583	96.2%
12003	$46750	130.0%
12005	$15625	43.5%
Annex		
27001	$29958	83.3%
Beaver Hills		
	N/A	N/A
Dixwell		
16002	$31490	87.6%
16006	$27153	75.5%
Downtown		
	N/A	N/A
Dwight		
	N/A	N/A
East Rock		
	N/A	N/A
East Shore		
28003	$51033	142.0%
Edgewood		
	N/A	N/A
Fair Haven		
23001	$31071	86.4%
23004	$24375	67.8%
23005	$28864	80.3%
24003	$22721	63.2%
Fair Haven Heights		
	N/A	N/A

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Median Family Income, New Haven Block Groups

- Eight block groups have median family incomes between 50 and 75 percent of the citywide median – one each in Newhallville, Quinnipiac Meadows and Wooster Sq./Mill River, two in Fair Haven, and three in Hill.
- Three block groups have median family incomes greater than 125 percent of the city's median family income – one each in Amity, East Shore, and Prospect Hill.

The overall range of percentages goes from about 36 percent to 142 percent. Clearly there are substantial differences in income between neighborhoods, and in some cases striking differences within neighborhoods, particularly in Amity and Hill, where many of the NFN families reside.

(Cont) Median Family Income in Block Groups where NFN Families Reside		
Block Group	**Median Family Income**	**% New Haven Median Family Income**
Hill		
02001*	$12893	35.9%
03002	$32778	91.2%
04001	$38250	106.4%
04003	$25917	72.1%
05001	$31071	86.4%
05002	$24740	68.8%
06001	$33750	93.9%
06003	$35164	97.8%
06004	$24438	68.0%
Long Wharf		
02001*	$12893	35.9%
Newhallville		
15001	$19167	53.3%
15007	$32292	89.8%
Prospect Hill		
18004	$48906	136.0%
Quinnipiac Meadows		
26013	$26116	72.6%
West River		
08004	$38000	105.7%
West Rock		
	N/A	N/A
Westville		
13003	$39375	109.5%
Wooster Sq./Mill River		
21001	$19280	53.6%
* Block Group 02001 is in both Hill and Long Wharf neighborhoods, but NFN families reside only in Hill		

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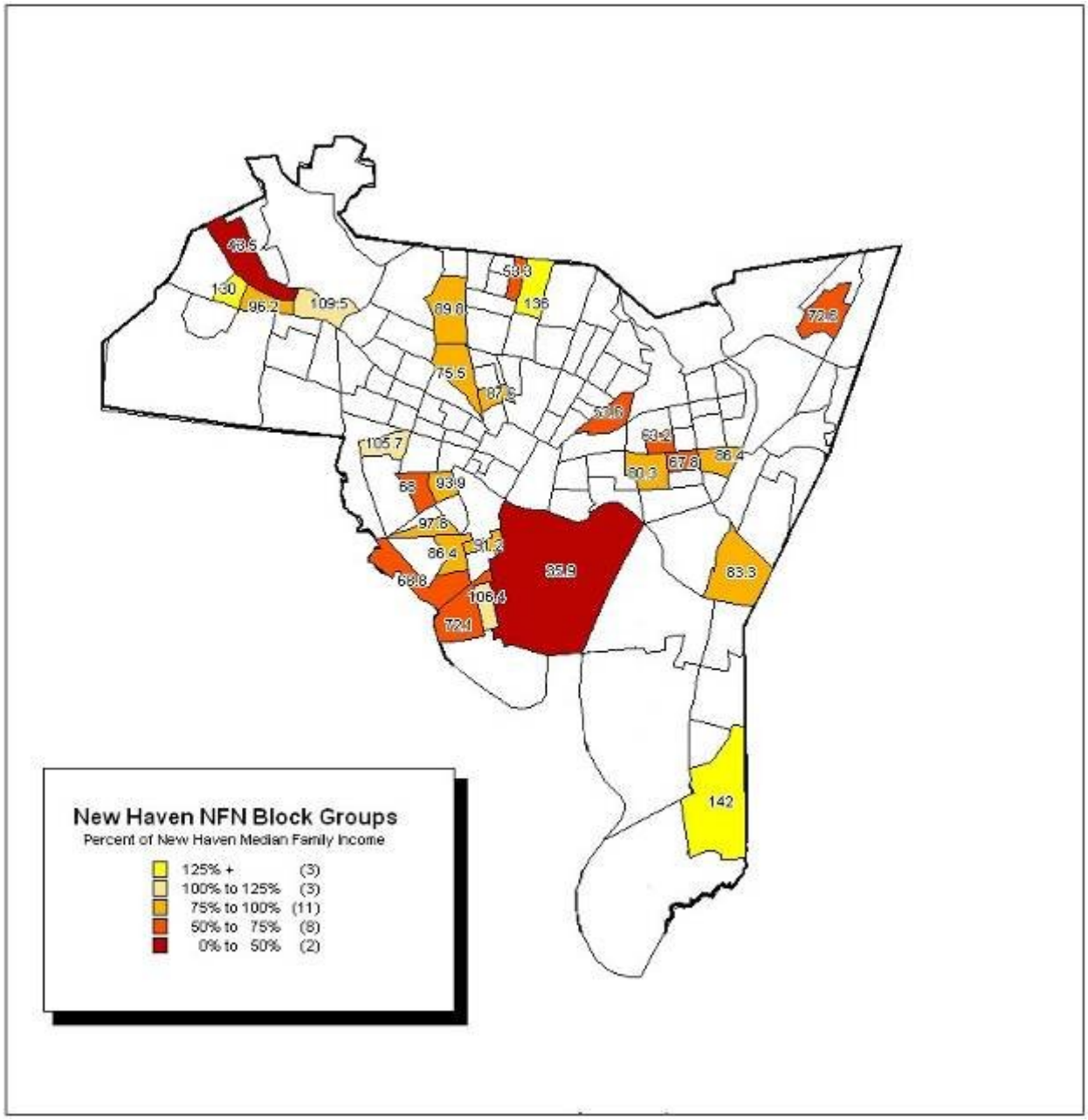
Median Family Income, New Haven Block Groups

Figure 18 shows the range of median family incomes across and within neighborhoods in comparison with the median income in the entire city, $35,950. For example, the median family income of two block groups fall below 50% of the citywide income while 3 block groups have incomes 125% or more, illustrating the striking differences in median family income between and within the neighborhoods where the NFN families reside.

Figure 18. Percent of New Haven Median Family Income by Block Groups



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Poverty Rates and Households without a Vehicle
New Haven NFN, 2007

Table 47 shows poverty rates as well as the percentage of households with no vehicles across the block groups. In general, block groups in which 30 percent or more residents live below the poverty line are considered high poverty geographical areas. Block groups with greater than 40 percent of residents below the poverty threshold are considered extremely high concentrations of poverty.

- Nine of the New Haven block groups with participating families are high poverty areas, one third of all block groups in this sample.
- Four block groups have extremely high concentrations of poverty. High and extremely high poverty areas are spread out through several neighborhoods: Amity, Dixwell, Fair Haven, Hill and Newhallville.
- Six block groups have less than 20 percent of residents below the poverty level, one each in the neighborhoods of Amity, East Shore, Newhallville, Prospect Hill, Quinnipiac Meadows, and West River.

Poverty is distributed among the neighborhoods with NFN families. Four of these block groups have greater than 25 percent of residents in extreme poverty, people living at less than one-half of the poverty line. These block groups are found in Amity, Fair Haven, Hill, and Newhallville. The data on households with no vehicle access also reflects the patterns of poverty. One third of all block groups with NFN participating families have more than 40 percent of their population without vehicle access.

Table 47. Poverty Rates and Percentage of Households without a vehicle by Block Group with NFN Families

	Households with No Vehicle		Income below poverty level		Income below 50% of poverty level		Income below 200% of poverty level	
Amity								
12002	71	19.8%	150	23.0%	83	12.7%	244	37.4%
12003	38	18.8%	42	8.9%	14	3.0%	127	26.8%
12005	171	50.6%	502	43.4%	379	32.7%	916	79.1%
Annex								
27001	96	18.5%	394	28.4%	246	17.8%	657	47.4%
Beaver Hills								
	N/A							
Dixwell								
16002	215	64.0%	202	32.7%	47	7.6%	313	50.6%
16006	184	46.6%	247	27.4%	46	5.1%	520	57.7%
Downtown								
	N/A							
Dwight								
	N/A							
East Rock								
	N/A							

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Poverty Rates and Households without a Vehicle
New Haven NFN, 2007

Table 47. (Cont.) Poverty Rates and Percentage of Households without a vehicle by Block Group with NFN Families								
East Shore								
28003	41	7.3%	58	4.5%	16	1.2%	216	16.6%
Edgewood								
	N/A							
Fair Haven								
23001	224	51.7%	213	24.6%	61	7.1%	423	48.9%
23004	107	39.2%	399	41.6%	171	17.8%	619	64.5%
23005	98	25.7%	317	25.9%	210	17.1%	676	55.2%
24003	84	24.8%	426	39.3%	306	28.2%	607	56.0%
Fair Haven Heights								
	N/A							
Hill								
02001*	570	74.3%	750	47.3%	358	22.6%	1341	84.6%
03002	85	35.3%	245	32.5%	204	27.1%	428	56.8%
04001	180	38.6%	418	28.2%	139	9.4%	772	52.1%
04003	169	43.1%	402	29.9%	169	12.6%	789	58.7%
05001	139	39.7%	285	27.6%	102	9.9%	579	56.1%
05002	132	37.9%	344	30.1%	184	16.1%	658	57.7%
06001	189	53.5%	209	26.3%	104	13.1%	383	48.1%
06003	93	32.7%	200	21.4%	111	11.9%	421	45.1%
06004	193	40.5%	411	30.8%	201	15.1%	742	55.7%
Long Wharf								
02001*	570	74.3%	750	47.3%	358	22.6%	1341	84.6%
Newhallville								
15001	74	30.5%	264	41.8%	221	35.0%	375	59.3%
15007	126	29.4%	185	17.5%	84	7.9%	453	42.8%
Prospect Hill								
18004	163	30.6%	228	19.9%	25	2.2%	418	36.5%
Quinnipiac Meadows								
26013	129	22.0%	215	16.4%	104	7.9%	672	51.3%
West River								
08004	135	31.5%	186	16.1%	64	5.6%	493	42.8%
West Rock								
	N/A							
Westville								
13003	150	30.7%	204	26.1%	140	17.9%	342	43.7%
Wooster Sq./Mill River								
21001	277	47.9%	401	28.3%	289	20.4%	1038	73.4%
* Block Group 02001 is in both Hill and Long Wharf neighborhoods, but NFN families reside only in Hill								

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New Haven NFN Program Sites

Five new programs in New Haven began serving families in October of 2007, one of which only provided screening and connections services for 2007 and did not initiate home visitation until the 2008 program year. There were already 3 programs operating in New Haven (also see Table 1). The locations of all 8 programs are provided on the map on page 40. Below are descriptions of all 8 programs; the first five on the list initiated services in 2007.

City of New Haven, Department of Health

The Health Department provides many health related program/services such as confidential HIV testing and counseling, house investigations for lead paint, investigations of health dangers, diabetes and nutrition education, HUSKY application assistance, Healthy Start, bereavement support, and preventative medical clinics.

The Children's Community Programs (CCP)

The Children's Community Programs has been in existence since 1999. CCP has several inter-related programs such as Therapeutic Foster care, Support Team for Educational Progress, One on One Mentoring and Post Legal Services. The agency works with families from Meriden, Middletown, and the greater New Haven area.

Fair Haven Community Health Center (FHCHC)

The Fair Haven health clinic opened in 1971 in a local elementary school. The health center also runs five school-based health centers and a satellite clinic for the elderly. They provide a variety of health services including prenatal, pediatric, adolescent services, women's health care, HIV care and behavioral health care. On site they also have a laboratory, WIC and nutrition services, and a wellness program.

Hill Health Center (HHC)

The Hill Health Center is the first community health center in Connecticut. Through the collaboration of the Yale Medical School and the community, HHC was established in 1968. HHC also provides services to families who live in West Haven, Lower Naugutuck Valley, Ansonia, Derby, Seymour, Shelton, Naugatuck and Oxford. Their program services include outreach to the homeless, birth to three, school-based health centers, HIV/AIDS education and outreach, alcohol and drug detoxification program, transitional shelter for the homeless and a guidance clinic for children and families.

Hospital of Saint Raphael (HSR)

The Hospital of Saint Raphael was founded in 1907 by the Sisters of Charity of Saint Elizabeth. HSR is affiliated with the Yale University School of Medicine. HSR is a nationally-respected hospital with a variety of services that services greater New Haven residents.

Yale New Haven Hospital (YNHH)

In 1917 the New Haven Hospital and the Yale School of Medicine joined together to form what is now YNHH YNHH provides the community with many different services. The services range from health care services to neighborhood redevelopment projects. YNHH has programs such as AIDS care, me & my baby, smoking cessation programs and a community wide asthma initiative.

Coordinating Council for Children in Crisis (CCCC)

Jean Adnopoz founded the Coordinating Council for Children in Crisis in 1977. He wanted to address the need for adequate support to families who were at risk of child abuse and neglect. CCCC provides the residents of New Haven with different programs and services focusing on families such as, a parenting education program, the Family Support Collaborative, Teen Outreach Program and the Neighborhood Victim Advocacy Program.

Visiting Nurse Association of South Central Connecticut (VNA/SCC)

The Visiting Nurse Association of South Central Connecticut was established in 1904. At that time the goal was to provide quality health care to the medically underserved. VNA/SCC provides services such as home health care, private duty, and also community programs.

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High Risk Families and Enrollment in NFN
New Haven Data, 2007

Disposition of Screens

Selection and assessment processes are the same as explained earlier in the report. The Revised Early Identification (REID) is used to determine eligibility for Nurturing Connections (low risk families) or Home Visitation (high risk families).

- Table 48 shows there were a total of 235 screens in New Haven from Oct to Dec 2007 and 133 of these first time mothers screened negative or at low risk for poor parenting; 57 low risk families were offered Nurturing Connections services and 24 accepted services.

Table 48. Disposition of Screens New Haven, October- December 2007

Total # of screens	**235**
# Negative screens	**133**
Offered Nurturing Connections	57 (43%)
Accepted Nurturing Connections	24 (42%)
# of positive screens	**102**
Offered home visiting	99 (97%)
Accepted Home Visiting	**44 (44%)**
Completed the Kempe	44 (100%)
Initiated services	41 (93%)

New Haven NFN: Profiles of High Risk Families

Table 49. Rates Of New Haven Mothers Scoring at Severe Risk as Measured by the Kempe Family Stress Checklist

New Haven Mothers' Kempe Scores 2007	0	5	10
1. Childhood History of Abuse/ Neglect (N=29)	55%	7%	38%
2. History of Crime, Substance Abuse, Mental Illness (N=29)	66%	17%	17%
3. CPS History (N=28)	86%	4%	11%
4. Low Self-esteem/ Social Isolation/ Depression (N=29)	59%	38%	3%
5. Multiple Stresses (N=29)	45%	21%	35%
6. Potential for Violence (N=28)	86%	7%	7%
7. Unrealistic Expectation of Child (N=29)	59%	38%	3%
8. Harsh Punishment (N=29)	90%	10%	0%
9. Negative Perception of Child (N=29)	97%	3%	0%
10. Child Unwanted/ Poor Bonding (N=29)	10%	86%	3%

Table 50. Mean CES-D Depression Score at Program Entry (N=24)	17.7
% Scoring Above Cutoff	63%

Enrollment of High Risk Families

- Forty-three percent, 102 first time mothers, were identified as high risk for poor parenting. The majority (99 families) were offered home visiting; a little less than half (44 families) accepted services and completed the Kempe; 41 families initiated services.

Table 49 gives participant scores on the Kempe Subscales. Given the small size of the New Haven sample, rates will be presented in number of families as well as percentages:

- On the Childhood History of Abuse/Neglect scale, 11 of 29 families (38%) scored at severe risk and 16 out of 29 scored at low risk.
- On the Multiple Stresses scale, 10 of 29 families scored at severe risk, 13 scored low risk.
- On History of Crime, Substance Abuse, Mental Illness scale, only 5 of the 29 scored at severe risk while 19 scored at low risk.
- Surprisingly, only 1 of the 29 families scored at severe risk on the Low Self-esteem/Social isolation/Depression scale, and 17 scored at low risk. This is inconsistent with mothers' scores on the CES-Depression scale, a self-reported instrument. As shown in Table 50, scores for 15 of 24 mothers (63%) were above the cutoff (>16) indicating that they experience a "clinically significant level of psychological distress" in their lives.

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Home Visitation Families at Program Entry
New Haven Data, 2007

Tables 51-53 present data on a range of factors including health (pregnancy and birth), social, and household information. Given the small sample size, these data will be presented in numbers rather than percentages in order for it to be more meaningful and better illuminate the circumstances of these families. The range in sample size is due to missing data..

Table 51. New Haven Mother's Pregnancy and Birth Information (N=19)

- 2 of 19 mothers reported that they smoked cigarettes during pregnancy
- All mothers reported that they did not drink alcohol during their pregnancy
- 1 mother used illicit drugs during her pregnancy
- 3 of 17 children were born with medical problems (e.g., breathing difficulties)
- 2 children were born prematurely (before 37 weeks gestation) and with low birth weight (under 5 lbs 8 oz)
- 18 of 19 children has a pediatrician, while for 1 child this is unknown

Table 52. New Haven Mother's Social Isolation, Arrest Histories, & Financial Difficulties

- According to the home visitors, 4 of 18 mothers are socially isolated
- 3 of 19 mothers reported having an arrest history
- 29 mothers completed the Kempe Family Stress Checklist:
  16 of 29 (55%) scored at Low-risk (scored 0-20)
  9 of 29 (31%) scored at Moderate risk (scored 25-35)
  4 of 29 (14% scored at High-risk (scored 40-60)
  None of the mothers (0%) scored at Severe risk (5-100)
  Average Total Kempe Score was 23
- According to the home visitors, 13 of 20 mothers (65%) have financial difficulties
- 2 of 17 mothers are receiving TANF
- 8 of 17 mothers are receiving Food Stamps

Table 53. Household Information, New Haven Data, 2007

- **Families Screened Prenatally:** Out of 30 participating mothers, 5 were screened prenatally
- **Marital Status:** 19 of 20 mothers are single and never been married, 1 mother is married
- **Mother's Race/Ethnicity—**Data collected on 21 families indicated:
  7 mothers are White,
  10 are African American,
  3 are Hispanic,
  1 is multi-racial
- **Mother age at Baby's Birth** (*Median Age is 20 years)*
  8 of 15 mothers were between the ages of 16 and 19 years of age;
  3 were between 20 and 22 years of age;
  1 was 26 or older
- **Maternal Grandmother Living in the Household:** 11 of 20 mothers are living with the maternal grandmother
- **Father Living in the Household**: 8 fathers out of 20 resides with the mother and child
- **Father's Involvement With Child**
  6 out of 14 fathers are Very involved
  3 out of 14 fathers are Somewhat involved
  2 out of 14 fathers Sees child occasionally
  2 fathers are Very rarely involved
  1 father Does not see baby at all

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Education and Employment Rates
Families at Program Entry, New Haven Data, 2007

Mother and father education and employment data are presented in Tables 54 and 55. Again, given the small sample size, these data will be presented in numbers rather than percentages.

Table 54. Mother Education and Employment Information, New Haven, 2007

Mother's Education (N=20)

- 8 out of 20 mothers have less than a high school education
- 9 mothers have a high school degree
- 2 mothers have some vocational training or college
- 1 mother has a college degree

Mother Enrolled in School (N=20)

- 10 of 20 mothers are enrolled in school

Mother's Employment Status (N=20)

- 15 out of 20 mothers are not employed
- 2 mothers are employed full time, 2 mothers are employed part time

Mother Employed Prior to Pregnancy: 11 of 20 mothers were employed prior to their pregnancy

Table 55. Father Education and Employment Information, New Haven, 2007

Father's Education (N=13)

- 1 out of 13 fathers has less than an 8th grade education
- 4 out of 13 fathers have less than a high school education
- 5 out of 13 fathers have a high school degree
- 3 of the 13 fathers have some vocational training or college

Father Enrolled in School (N=18)

- 3 of 18 fathers are enrolled in school

Father's Employment Status (N=17)

- 11 out of the 17 fathers are unemployed
- 6 fathers are employed: 5 are employed full time and 1 is employed part time

Fathers With an Arrest History: 9 of the 13 fathers have an arrest history (62%)

Fathers Currently Incarcerated: 2 of the 13 were incarcerated at the time of the baby's birth

Summary of Risk Profiles

Although New Haven NFN programs had only a small sample size at the end of 2007, the sum of these preliminary data indicate that this is a vulnerable group: All but one mother are not married, more than half are teenagers and more than one half are residing with the maternal grandmother. Most of these families have financial difficulties as reported by the home visitors. Almost one half of mothers and fathers have less than a high school education; in addition,15 of 20 mothers and 11 of 17 fathers were not employed at program entry. As with the statewide and Hartford data, there was a relatively high percentage of families that scored as Low Risk on the Kempe Family Stress Checklist; however, given these other risk indicators, once again this appears to be due to a change in eligibility requirements.

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Participation Rates & Program Outcomes, October-December, New Haven, 2007

Data in Tables 56and 57 report on program participation and referrals for community services for 44 families who enrolled in the New Haven NFN program from Oct-Dec, 2007.

- As Table 56 shows, families were seen in their homes, on average two times monthly. This is similar to the Hartford and statewide data. There were a total of 23 completed visits during that time period.
- As with the Hartford NFN program, community referrals are documented to assess service needs and the networks that NFN home visitation is part of. Table 57 shows that home visitors made 52 referrals on behalf of families from Oct-Dec, 2007. Similar to Hartford and statewide data, most of the referrals are to address basic needs (WIC, DSS, SS, Household) and for employment and education. Thus far, families followed up on 35 of these referrals, 67%.

Table 56.
Home Visitation Participation, New Haven, Oct-Dec 2007

Frequency of Home Visits at the New Haven Sites (N=44)	2007
Average # of attempted home visits	2.6
Average # of completed home visits	2.0
Average # of office/out of home visits	0.2
Average # of NFN social events attended	0.1
Total # of visits completed	2.3

Table 57. Community Referrals, New Haven NFN, Oct-Dec 2007

Number and Type of Referrals		# Referral Followed Up On	Number and Type of Referrals		Referral Followed Up On
WIC	4	3	Mental health/counseling	0	0
DSS	6	6	Crisis intervention	0	0
Social Security	2	2	Parenting class/program	4	3
Food needs	0	0	Domestic violence	0	0
Doctor/medical services	1	0	Substance abuse	0	0
Housing needs	1	1	Employment/education	9	3
Legal needs	0	0	Department of Children & Families	1	1
Household needs	2	1	Recreation	2	2
Early intervention/day care	2	1	Cultural/religious	0	0
			Other	18	12
52 Referrals on Behalf of Families from Oct to Dec 2007					
Families followed up on 35 referrals (67% of referrals)					

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Description of Outcome Measures
New Haven NFN

Because participants in the New Have NFN program have been receiving services for only 3 months as of the end of 2007, we will not be including outcome data (with exception of community referrals). Outcome data will be provided on a range of measures next year. The outcome design of this study, the same as for statewide and Hartford NFN is a pre and post assessment, so we will measure changes cross time among families in areas where the program is targeting its intervention. We will be using a range of standardized instruments as described below.

Child Abuse Potential– Rigidity (CAPI-R)

The CAPI rigidity subscale is a self-report scale that *measures the rigidity of attitudes and beliefs about the appearance and behavior of children*, with the theoretical assumption that rigid attitudes and beliefs lead to a greater probability of child abuse and neglect. The reliability coefficient for the CAPI Rigidity subscale ranges from .77 to .80. (Milner, J.S., 1986. *Child Abuse Potential Inventory: Manual (2nd Edition*). Psytec Corporation. Webster, NC)

The Conflict Tactics Scale – Parent Child version (CTS-PC)

The CTS-PC is a 35-item questionnaire which *measures how often parents used specific acts of discipline (both violent and nonviolent) with their child in the past year.* It does not measure whether or not the child was injured. The CTS-PC also has a supplemental scale on neglect. There are six subscales of the CTS-PC: nonviolent discipline, psychological aggression, minor physical assault, severe physical assault, very severe physical assault, and neglect. Internal consistency estimates range from 0.55 to 0.70. (Straus, M.A., 2003. *The Conflict Tactics Scales Handbook*. Western Psychological Services. Los Angeles, CA)

Community Life Skills Scale

The CLS is a 33-item yes/no scale that *measures a family member's use of community resources and her ability to negotiate for herself and her family in the community*. The 33 items cover six major categories: Transportation, Budgeting, Support Services, Support Involvement, Interests-Hobbies, and Regularity-Organization-Routines. Internal consistency estimates range from .63 to .69. The CLS showed a positive correlation with the NCAST Feeding and Teaching Scales as well as the HOME Inventory. (Barnard K., 1991. *The Community Life Skills Scale*. NCAST: Seattle, WA)

Center for the Epidemiological Studies Depression (CES-D) Scale

The CES-D is a 20-item, self-report scale of depression intended for the general population. The CES-D is rated on a four point scale in which participants respond how often they felt certain emotions over the past week. The CES-D *measures depressed mood, feelings of guilt and worthlessness, feelings of helplessness and hopelessness, loss of appetite, sleep disturbances, and psychomotor retardation.* The CES-D has internal reliability estimates of between .84 to .90. (Radloff, L. S. , 1977. The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement, 1,* 385-401)

Parent Stress Index– Short Form (PSI-SF)

The PSI-SF is *designed for the early identification of parenting and family characteristics that fail to promote normal development and functioning in children, children with behavioral and emotional problems, and parents who are at-risk for dysfunctional parenting.* High parental stress, as measures by the PSI, has been shown to be related to decreased infant attachment, increased behavioral problems in children, increased maternal depression, increased neglectful parenting, and greater risk of physical child abuse. Internal consistency estimates range from 0.78 to 0.90 for the total scale while test-retest reliability coefficients range from 0.68 to 0.85. (Abidin RR. *Parenting Stress Index Short Form: Test Manual*. Charlottesville, VA: Pediatric Psychology Press; 1990)

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2007 New Haven Data Analysis: Summary of Key Findings

Regional Inequality

- Like Hartford, New Haven has a high concentration of parents living in poverty. In comparison to the other 20 towns in the region, New Haven stands alone as having by far the highest rates of poverty at 24.4%.
- At $35,950, New Haven's average median family income is only 49% of the regional average, $73,540.
- There is a total of 5,377 children, birth to 5 years of age, who live in poverty in the region. Sixty-two percent, 3,334 of these children, reside in New Haven.

Enrollment Rates

- There were a total of 235 mothers who were screened for services in New Haven from Oct to Dec 2007; 133 of these first-time mothers were identified as low risk for poor parenting; 57 of these families were offered Nurturing Connections services and 24 accepted services.
- There were 102 first time mothers identified as high risk for poor parenting (43% of the total screens); the majority (99 families) were offered home visiting and 41 families initiated services between October and December of 2007.

Risk Profiles

- Although New Haven NFN programs had only a small sample size at the end of 2007, the sum of these preliminary data indicate that this is a vulnerable group: All but one mother are not married; more than half are teenagers; more than half are residing with the maternal grandmother; and almost one half of these mothers have less than a high school education. Most of these families have financial difficulties as reported by the home visitors. Fifteen of 24 of these mothers' self-reports on the CES-Depression scale indicated they were experiencing depression.
- As with the statewide and Hartford data, there was a relatively high percentage of New Haven NFN families that scored as Low Risk on the Kempe Family Stress Checklist; however, given these other risk indicators, once again this appears to be due to a change in eligibility requirements.

Community Referrals

- Similar to the Hartford NFN program, community referrals are documented to assess service needs and the networks that NFN home visitation is part of. Home visitors made 52 referrals from October through December of 2007 in support of NFN families. Most of the referrals were to address basic needs (WIC, DSS, SS, Household) or were related to employment and education. Thus far, families followed up on 67% or 35 of these referrals.

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State Reports of Child Maltreatment 2006/2007

In this next section, we report on both substantiated and unsubstantiated reports of abuse and neglect for all families, statewide, who signed a release allowing us to search the Department of Children and Families (DCF) database to determine if there were any reports of maltreatment during their tenure in the home visitation program. We also take a closer look at the discipline methods used by Hartford NFN families in this section, including self reports of abuse and neglect as measured by the Parent-Child version of the Conflict Tactics Scale (CTS-PC), We cross reference these particular cases of self-reported child maltreatment with state reports.

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Rates of Maltreatment for the NFN Population, 2006/2007

Each year, program participants are asked to sign a release form that allows us to search the Department of Children and Families (DCF) database to determine whether or not they have been reported for maltreatment during their tenure in the home visitation program.

- This year, 614 families who participated in the program at any time between July 1, 2006 and June 30, 2007 signed the release, representing 46 percent of all families who were active during that time (N=1339).
- Fifty-two percent of families had exited the program before a current release was signed while only two percent refused to sign. These data include participants from all NFN sites, excluding the sites that began in 2007 (these programs started services after our cutoff date).

We analyzed demographic and risk data to determine if those who signed the release differed from those who did not. Results of this analysis are presented in Table 58. These data show that the two groups were comparable across all the factors from risk factors to education, employment, and racial/ethnic group. This increased our confidence that the group excluded from our analysis was not at higher risk than the group included in our analysis.

Table 58. Comparison of Families Included and Excluded in Analyses of Abuse and Neglect Reports, Statewide Data, 2006/2007

Demographic and Risk Data	Signed DCF Release (N=614)	Did Not Sign DCF Release (N=725)
CAPI Rigidity score	21.8	21.3
Mother's total Kempe score	36.6	36.7
Mother's age at baby's birth	21.8	21.3
% Mothers with at least a high school degree	51%	48%
% Mothers employed	22%	22%
% Mothers nonwhite	78%	77%

Similar to previous reports, this year's DCF data is analyzed in three different ways

- First, we assessed families reported for maltreatment at any time during their participation in the program.
- Second, we assessed all families who were reported to DCF during their participation between July 1, 2006 and June 30, 2007.
- Third, we assessed only those families who were active in the program for the entire year, July 1, 2006 to June 30, 2007. The purpose of this analysis is to standardize the exposure that a family has to the NFN program and to calculate rates that could be compared to state and national rates.

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Rates of Maltreatment for the NFN Population, 2006/2007

Assessment of families reported for maltreatment at any time during their participation in the program

Twenty percent of all families had a DCF report filed at some time during their participation in the program, an increase from last year's rate of 15.5%, but still not as high as the 2005 rate of 22%. Six percent of families had a substantiated report in 2006/2007 year, the same rate of substantiated reports as the prior year.

Table 59.
Reports of Child Maltreatment for Families at Any Time During Program Participation

DCF Data on NFN Families	2004-2005	2005-2006	2006-2007
Total number of families that signed DCF release	410	664	614
# of families with DCF Report	92 (22.4%)	103 (15.5%)	122 (19.9%)
# of families with multiple DCF reports	40 (9.8%)	33 (5.0%)	36 (6.0%)
# of families with substantiated DCF report	32 (7.8%)	37 (5.6%)	34 (5.5%)
# of families w/multiple substantiated DCF Reports	7 (1.7%)	4 (0.6%)	5 (.8%)
Total number of reports	157	146	186
Total number of substantiated reports	41	41	41

Assessment of all families reported for maltreatment between 7/1/06 and 6/30/07

In the second analysis 9% of participating families had a report filed between July 1, 2006 and June 30, 2007, a slight increase from last year's rate of 8% , and 3% had a substantiated report. These data indicate a slight increase in maltreatment rates from last year.

Table 60.
All Reports of Child Maltreatment Made Between 7/1/06-76/30/07

DCF Data on NFN Families	2004-2005	2005-2006	2006-2007
Total number of families that signed DCF release	410	664	614
# of families with DCF Report	45 (11.0%)	55 (8.3%)	53 (8.9%)
# of families with multiple DCF reports	7 (1.7%)	7 (1.1%)	14 (2.3%)
# of families with substantiated DCF report	12 (2.9%)	14 (2.1%)	17 (2.8%)
# of families with multiple substantiated DCF Reports	0 (0%)	0 (0%)	2 (0.3%)
Total number of reports	53	61	69
Total number of substantiated reports	12	14	19

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Annualized Rates of Maltreatment for the NFN Population, 2006/2007

Assessment of families reported for maltreatment who were active in the program for the entire year between 7/1/06 and 6/30/07

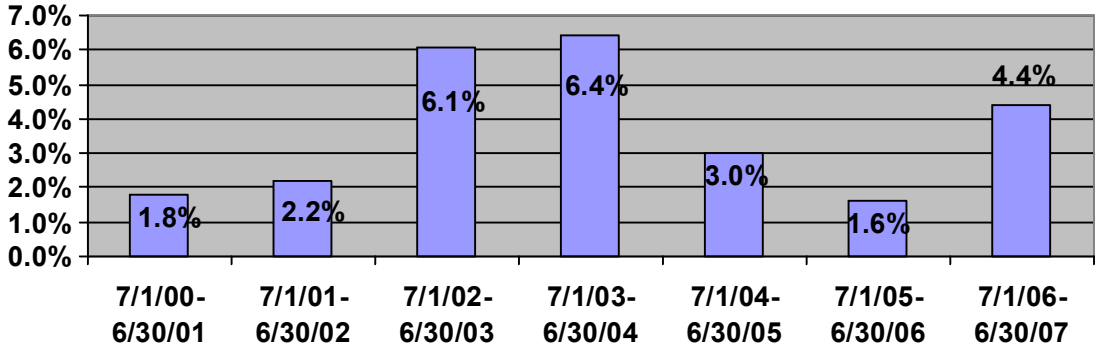
In our final analysis, we calculated an annualized rate of maltreatment, including only the 249 families who received services for the entire year. DCF reports were filed on 12 percent of these families and substantiated for 4 percent, a noted increase over the previous two years.

Table 61
Reports of Child Maltreatment for Families
Active for the Entire Year Between 7/1/06-6/30/07

DCF Data on NFN Families	2004-2005	2005-2006	2006-2007
# of families active the entire year 7/1/06-6/30/07	229	256	249
# of families with DCF report 7/1/06-6/30/07	35 (15.3%)	20 (7.8%)	31 (12.4%)
# of families with multiple DCF reports	6 (2.6%)	3 (1.2%)	11 (4.4%)
# of families with substantiated DCF report	7 (3.1%)	4 (1.6%)	11 (4.4%)
# of families with multiple substantiated DCF reports	0 (0%)	0 (0%)	1 (0.4%)
Total number of reports	43	23	45
Total number of substantiated reports	7	4	13

Figure 19 shows the annualized rate of maltreatment for the past seven years for the NFN population. As shown, the rates peaked in 2002-2003 and 2003-2004, then declined for the next two years before increasing this year.

Figure 19. Annualized Rates of Maltreatment for the NFN Population 2000-2007



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Type and Perpetrator of Maltreatment, 2006/2007

Perpetrators of Abuse

As presented in Table 62, NFN mothers were perpetrators in 86 percent of all reports and 75 percent of substantiated cases. Fathers were involved in 37 percent of all cases, but in 44 percent of substantiated cases. Families, on average, had been in the NFN program for 10 months when a substantiated report was filed and home visitors made 17 percent of these reports.

As in previous years, domestic violence and drug use were common reasons why reports were made. About one-third of all substantiated reports involved domestic violence and another one-fifth substance use, while slightly more than one-third of cases also involved a parent with a mental illness or cognitive delay.

Table 62. Relationship of Perpetrator to Child

Perpetrator of Maltreatment	ALL Reports (N=186)	Substantiated Reports (N=41)
	(N=184)	(N=41)
Mother only	55%	48%
Mother and father	24%	24%
Father only	13%	20%
Mother and maternal grandmother	2%	0%
Mother and mother's boyfriend	2%	2%
Mother and other family member	3%	0%
Maternal grandmother	1%	2%
Mother's boyfriend only	2%	2%
Home Visitor Made Report to DCF	13%	17%
Domestic Violence Involved in Report	24%	34%
Drugs Involved in Report	14%	20%
Parent has Mental Illness or Cognitive Deficit	37%	37%
Child has Mental Illness or Cognitive Deficit	3%	0%
Average Length of Time in Program When Report Occurred	13 months	10 months

Prevalence of Physical and Emotional Neglect

As shown below in Table 63, physical neglect was by far the most prevalent type of maltreatment that occurred (80% of all substantiated cases), followed by emotional neglect (29% of all substantiated cases). According to the Connecticut Department of Children and Families, physical neglect is defined as "the failure to provide adequate shelter, food, clothing, or supervision which is appropriate to the climatic and environmental conditions. Physical neglect may also include leaving a child alone for an excessive amount of time given the child's age and cognitive abilities and holding the child responsible for the care of siblings or others beyond the child's ability."

Table 63.
Types and Frequency of Child Maltreatment

Type of Maltreatment	ALL Reports (N=186)	Substantiated Reports Only (N=41)
Physical Neglect	78%	80%
Emotional Neglect	30%	29%
Physical Abuse	8%	5%
Sexual Abuse	2%	2%
Medical Neglect	2%	2%
Moral Neglect	1%	0%
Emotional Neglect	1%	0%

Two Cases of Physical Abuse

There were 2 cases of substantiated physical abuse. Because we include reports at any time during their participation in the program, one of the two substantiated cases of physical abuse was described in a previous report. One additional case of physical abuse occurred in 2006 (family had not signed the release last year) and involved a mother leaving her child with her boyfriend (who was not the father of the baby). The child sustained facial bruising and scratches from the mother's boyfriend, and the mother delayed in seeking medical attention for the child. The mother's boyfriend was substantiated for physical abuse and the mother was substantiated for medical neglect.

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Parent Discipline Methods:Conflict Tactics Scale
Hartford Data, 2005 & 2006 Cohorts

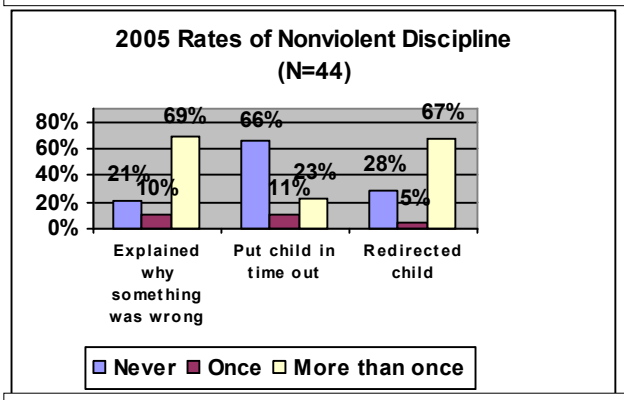
Discipline methods, Comparison of 2005 and 2006 Cohorts

The Parent-Child version of the Conflict Tactics Scale (CTS-PC), introduced in 2005 with the Hartford NFN expansion, is a self-report measure that assesses how often parents used specific acts of discipline including nonviolent discipline, psychological aggression, physical assault, and neglect.

Hartford program participants complete the CTS-PC around their children's first birthday and at subsequent birthdays. Although we have data for 2 separate cohorts (44 mothers in 2005 and 40 mothers in 2006), we do not have enough data yet to assess change from the time the child is 1 year to 2 years old. In the next several tables we report on rates of nonviolent discipline, psychological aggression and rates of relatively minor "corporal punishment" for the 2 separate cohorts.

- Figure 20 shows rates of nonviolent discipline for each of the 2 cohorts, 2005 and 2006, and Figure 21 shows rates of psychological aggression for each of the 2 cohorts.
- For both years, similar percentages of mothers used nonviolent discipline methods including explaining why something was wrong and redirecting bad behavior. However, the 2005 cohort, in comparison with the 2006 cohort, used time-out more frequently.
- In addition, the 2005 cohort, in comparison with the 2006 cohort, used psychological aggression more frequently. Specifically, more of the mothers from the 2005 cohort reported that they had screamed, shouted or yelled at their child, threatened to spank their child at least once, and slapped their child on the hand, leg, or arm at least once.

Figure 20. Conflict Tactic Scale: Rates of Nonviolent (proactive) Discipline
Mothers with 1 year old child in 2005 compared with 2006



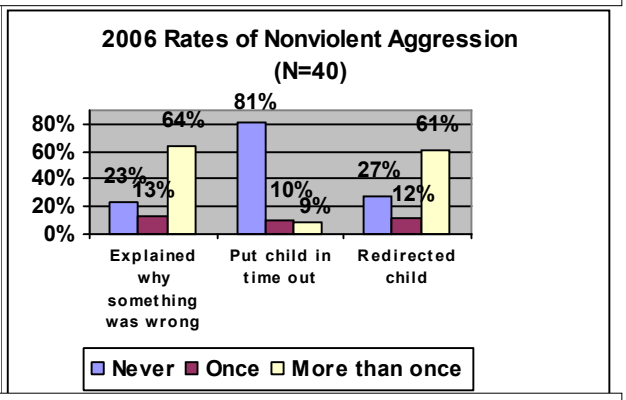
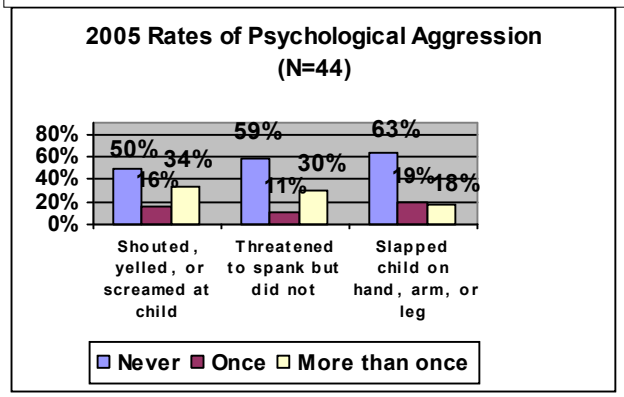
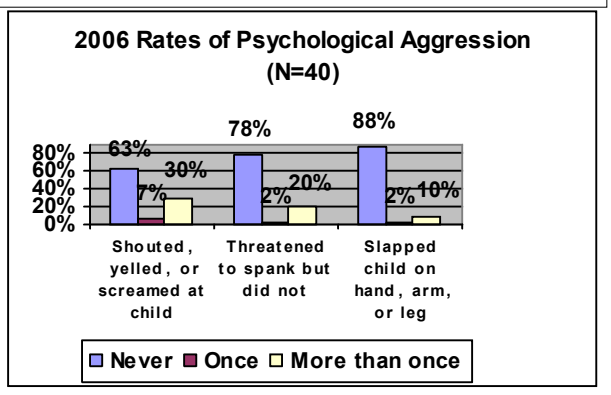


Figure 21. Conflict Tactic Scale: Rates of Psychological Aggression
Mothers with 1 year old child in 2005 compared with 2006





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Parent Discipline Methods:Conflict Tactics Scale
Hartford Data, 2005 & 2006 Cohorts

Discipline Methods in the Past Week

In addition to reporting discipline methods for the past year, mothers are also asked to report on the discipline methods they used in the past week.

Tables 64 and 65 show mothers' ratings on their discipline methods "in the past week" for the 2005 (N=44) and 2006 (N=40) cohorts. When comparing mothers' reports on their discipline patterns for the past *year* with their discipline methods for the past *week*, there is a similar pattern between the two cohorts.

- As compared with the 2006 cohort, there were more mothers in the 2005 cohort who reported that they put their child in time out, shouted, yelled or screamed at their child, spanked their child's bottom with their bare hand, and slapped their child on the hand, arm, or leg.

Change Over Time

We do not have data yet to assess change over time for either cohort (i.e. change between mothers' self reports on their discipline methods at their child's 1st birthday to their child's 2nd). It will be important to document change for these cohorts over the next year (at children's 2nd birthday) and see if these two groups continue to look distinct from the each other in terms of discipline methods.

Table 64 Discipline Methods Used on 1 Year Old Children in Past Week, Hartford Data, 2005 Cohort (N=44)

Discipline Methods in Past Week (N=44)	Never	Once	More Than Once
Put child in time out	76%	11%	13%
Shouted, yelled, or screamed at child	74%	18%	8%
Spanked child on bottom with bare hand	87%	5%	8%
Slapped child on hand, arm, or leg	71%	16%	13%

Table 65 Discipline Methods Used on 1 Year Old Children in Past Week, Hartford Data, 2006 Cohort (N=40)

Discipline Methods in Past Week (N=40)	Never	Once	More Than Once
Put child in time out	85%	8%	7%
Shouted, yelled, or screamed at child	85%	3%	12%
Spanked child on bottom with bare hand	95%	3%	2%
Slapped child on hand, arm, or leg	94%	3%	3%

Self-Reports of Abuse and Neglect
Hartford Data, 2005 and 2006 Cohorts

Self-reports on the Conflict Tactics Scale also indicated that there was a small number of mothers who spanked their child with their bare hand: 8 mothers in the 2005 cohort and 4 mothers in the 2006 cohort. A few parents reported "acts of physical assault" and "neglect" of their child on the Conflict Tactics Scale (CTS-PC). The following data are parents' self-reports on survey items that fall within these categories.

2005 Cohort

- 1 parent hit her child once on the bottom with something like a belt, brush, stick or other hard object
- 2 parents swore or cursed at their child at least once, 2 parents reported doing this more than 1 time
- 1 parent reported pinching her child
- 1 parent called her child "dumb or lazy or some other name like that" at least once, 1 parent reported doing this more than once
- 1 parent was not able to get the food her child needed on at least one occasion
- 1 parent was not able to make sure her child got to a doctor or hospital when he or she needed it

2006 Cohort

- 1 parent hit her child with a fist or kicked her child hard on 1 occasion
- 1 parent swore or cursed at her child at least once, 1 parent reported doing this more than 1 time
- 1 parent called her child "dumb or lazy or some other name like that" at least twice
- 1 parent reported leaving her child home alone on at least 2 occasions

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Cross Reference of Mothers' Self-Reports with State Reports of Abuse and Neglect

In total, there were six mothers in the 2005 cohort that reported abusive or neglectful behaviors on the CTS-PC (see p. 60). Four of these mothers were included in our DCF analysis, however, only one of these mothers had a substantiated report of maltreatment (physical abuse). The other three mothers did not have any DCF reports.

While there were five mothers in the 2006 cohort that reported abusive or neglectful behaviors on the CTS-PC, none of these mothers had a substantiated report of maltreatment. Two families each had one unsubstantiated report, two had no reports, and one was not included in our DCF analysis.

Summary of Reports of Abuse and Neglect

- The rate of child maltreatment this year, 4.4 percent, indicates an increase in the 2006-2007 time period as compared to the previous two years.
- Physical neglect was by far the most prevalent type of maltreatment that occurred (80% of all substantiated cases), followed by emotional neglect.
- NFN mothers were perpetrators in 86 percent of all reports and 75 percent of substantiated cases. Fathers were involved in 37 percent of all cases, but in 44 percent of substantiated cases.
- Families, on average, had been in the NFN program for 10 months when a substantiated report was filed and home visitors made 17 percent of these reports.
- As in previous years, domestic violence and drug use were common reasons why reports were made. About one-third of all substantiated reports involved domestic violence and another one-fifth substance use, while slightly more than one-third of cases also involved a parent with a mental illness or cognitive delay.
- Hartford NFN mothers' self reports on their discipline methods on the Parent-Child version of the Conflict Tactics Scale (CTS-PC) have been collected for two cohorts: participants entering the program in 2005 and 2006. A small number of these mothers reported "acts of physical assault" and "neglect" of their child on the CTS-PC. Of the 11 mothers who made these reports, one of them had a substantiated state report of maltreatment, and two had unsubstantiated DCF reports. There were no state reports for the eight remaining mothers.

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Nurturing Parenting Groups Statewide Data

The Nurturing Parenting Groups make up the third component of the Nurturing Families Network. These groups are based on the Nurturing Program developed by Stephen Bavolek. In this section we report on the social demographic characteristics of the group participants, attendance rates by type of curricula, and parent outcomes as measured by the Adult-Adolescent Parenting Inventory-2 and the Parenting Stress Index-Short Form.

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Nurturing Parenting Groups: Social Demographic Data Statewide, 2007

Table 66. Nurturing Group Participants' Social Demographic Characteristics	N	%
Participant's Gender	497	
Male		11%
Female		90%
Participant's Age	481	
Under 16 years		4%
16-19 years		26%
20-22 years		15%
23-25 years		14%
26-30 years		16%
Over 30 years		24%
Mean Age		26 yrs
Mean Number of Children Participant Has	499	1.6
Participant's Race/Ethnicity	499	
Hispanic		39%
White		32%
African American		20%
Other		9%
Language Participant is Most Comfortable Speaking	498	
English		66%
Spanish		14%
English and Spanish		20%
Other		1%
Participant's Employment Status	497	
Not employed, not seeking work		42%
Not employed, but seeking work		27%
Employed full-time		13%
Employed part-time		13%
Occasional work or more than one job		4%
On maternity leave		2%
Participant Enrolled in School	493	32%
Yes		32%
High school		20%
College		3%
GED Program		2%
Vocational school		<1%
Other type of schooling		5%
Partner's Marital Status	496	
Single, never married		65%
Married		28%
Separated, Divorced, or Widowed		7%
Participant Has a Partner?	344	67%
Partner is enrolled in group		13%
Mean # of Adults in Household	469	1.76

Nurturing Group Participants' Social Demographic Characteristics

- As in previous years, most participants (90%) were women and only 10% were men.
- Participants were racially and ethnically diverse, with almost 40 % Hispanic, 32 % White, and 20 % African-American.
- Participants' ages varied, with the program drawing heavily from the 16 to 19 age group (26%), but also the over 30 age group (24%).
- Slightly less than one-third of participants were employed, with about one-half of those working full-time.
- About one-third of participants were enrolled in school, mostly of which were in high school.
- Two-thirds reported involvement with a partner, although only 28 % were married.

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Nurturing Parenting Groups Outcomes
Statewide Data, 2007

Nurturing Group Attendance

As shown in Table 67, there were several different curricula that sites used in 2007, with most choosing the Birth to Five and Prenatal curricula. Rates of graduation differed by the type of curricula used. Completion rates ranged from 49 percent (Birth to Five curricula) to 90 percent (Community Based Education in Nurturing Parenting).

Table 67. Nurturing Group Attendance Rates by Type of Curricula

Type of Curricula	N	Length of Curriculum	Av. # sessions offered	Av. # sessions attended	% Graduated
Birth to Five	187	24	17	9	49%
Prenatal	183	9	10	6	62%
Nurturing Skills for Families	11	D/K	15	13	82%
Nurturing for Spanish Speaking Parents	14	D/K	15	11	57%
ABCs of Parenting	54	D/K	13	7	56%
Nurturing Fathers	8	13	13	5	75%
Nurturing for Teen Parents	52	26	19	11	60%
Community Based Education in Nurturing Parenting	10	10	10	7	90%

Adult-Adolescent Parenting Inventory-2

Prenatal parents showed significant and positive change on the Adult-Adolescent Parenting Inventory (Table 68.), suggesting that, overall, parents displayed healthier parenting attitudes and more age appropriate expectations of their children upon completion of the groups.

Table 68. Adult-Adolescent Parenting Inventory-2 Outcomes for Prenatal Families (N=83)

Scale	Pre	Post
AAPI-2 Total Score	132.9	147.2***

Parenting Stress Index-Short Form

There were statistically significant changes in the desired direction on the Overall Stress scale on the Parenting Stress Index-Short Form (PSI-SF), as well as the Parent-Child Dysfunctional Interaction and Difficult Child subscales (Table 69). In general, these scores indicated that parents were experiencing greater parenting competence and less stress in their parental roles.

Table 69. Parenting Stress Index-Short Form Outcomes for Post-Natal Families (N=121)

PSI-SF Scale	Pre	Post
Parental Distress	28.4	26.2
Parent-Child Dysfunctional Interaction	20.7	17.6**
Difficult Child	26.4	23.3***
Total Stress	80.3	65.1*

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Research Projects

In the next section two papers present the findings of qualitative research exploring the processes : In *Life Stories Final Report,* four topics are explored: childcare needs and barriers; the effects of child sexual abuse; high school completion among adolescent mothers; and the unique vulnerabilities of very young mothers. These issues were explored to better understand the ways that the NFN program can address the needs of this population. What we learn from the mothers themselves is that one of the most important roles the home visitor can play is to develop a strong trusting relationship with the mother. In *Revisiting the Cultural Broker Model*, data from focus group discussions with Hartford NFN program staff are presented. The focus groups were designed to elucidate the decision processes of the home visitors in identifying family needs and helping families obtain resources and connect to community services. Analyses of these data highlight both the central importance of the home visitor in developing a strong trusting relationship with the mother and the pivotal role of the clinical supervisor for making the paraprofessional model more effective.

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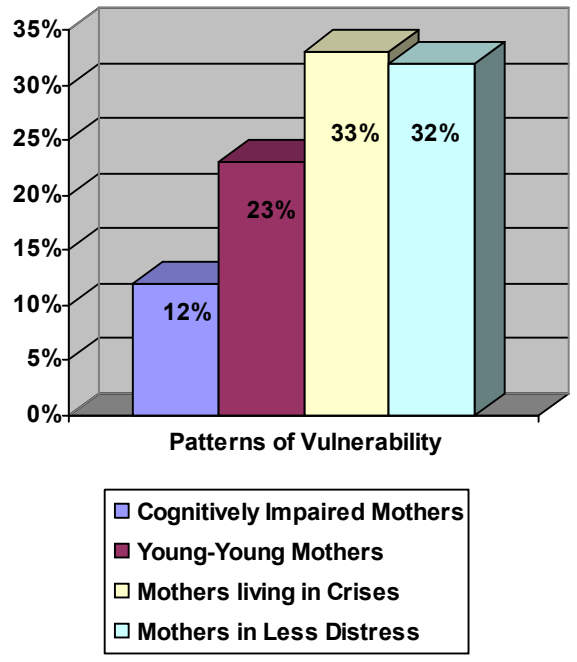
LIFE STORIES FINAL REPORT

by Mary Patrice Erdmans

Updates on the Life Stories

This study was designed to learn about the Nurturing Family Network program from the perspective of the participants. Toward this end, we used a life story interview – an oral autobiography – to learn about their family background, current living conditions, and involvement in the NFN program. We conducted the life-story interviews with 171 mothers and 48 fathers between January 2002 and March 2003. See Figure 22 for a categorization of NFN mothers in this study by primary types of vulnerability. Our 2004 report summarized the findings of this research, focusing on the types of vulnerabilities representative of mothers in the NFN program and the ways that mothers engage with their home visitors.

Fig. 22. Connecticut's Vulnerable Families



Subsequent to this report, we explored four other topics: childcare needs and barriers; the effects of child sexual abuse; high school completion among adolescent mothers; and the unique vulnerabilities of very young mothers.

- **Childcare:** In order to continue their education or move into the workforce, mothers must rely on childcare. Who are their formal and informal child care providers? What are the barriers to quality child care? How can NFN workers help mothers access quality child care?
- **Child Sexual Abuse:** Victims of child sexual abuse are vulnerable to perpetuating cycles of abuse. What can we learn from the life stories to better understand the trajectories of sex abuse victims in order to stop the cycle of abuse?
- **High school completion:** One reason adolescent childbearing is problematic is that young mothers are at risk of dropping out of high school. What are the differences between adolescent mothers who complete high school and those who do not? How can NFN workers help mothers return to school or stay in school?
- **Children having children:** The vulnerabilities of first time mothers are intensified by young age. Who are the mothers who give birth before the age of 16, and in what ways can NFN workers help young young mothers parent?

These issues were explored to better understand the ways that the NFN program can address the needs of this population and augment the initial report that categorized the vulnerabilities of mothers in the program and the nature of the relationship between them and their home care providers.

Childcare Needs and Barriers

Almost two-thirds of all children in the United States between birth and age six (and not yet in kindergarten) are cared for by someone other than a parent on a regular basis. While the primary function for child care is to care for children so that parents can work, a second purpose is to enhance child development. Indicators such as improved cognitive and language skills, fewer behavioral problems, and better social skills are associated with high quality child care. This relationship is particularly evident with low-income children

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for whom high quality child care programs help offset disadvantaged home environments (Burchinal 1999; Scarr 1998). Unfortunately, barriers to quality childcare limit these potential benefits, for NFN participants as well as many disadvantaged families in the United States (see Capizzano and Adams 2003; Mezey et al 2002).

Mothers whose children are less than two years of age prefer to have their children cared for in the home or by a family member. This is true for both the NFN participants as well as most mothers in the United States regardless of class, race or ethnicity. For our participants, only 15 percent of mothers whose children were under one year of age used a child care provider outside of the family network, compared to 41 percent with children between the ages of one and three, and 52 percent with children over three years of age.

Barriers to daycare for low income families in general included prohibitive costs, availability, convenience (transportation), and negative perceptions of childcare. These barriers were also mentioned by many of the participants in the life stories.

- In general, low-income mothers can not afford quality childcare and despite being eligible for federal funding many do not receive assistance (Mezey et al 2002). Between 2002 and 2007, funding for Care4Kids in Connecticut was cut by 41 percent; and in 2001 only 8 percent of the estimated 170,000 children eligible for Child Care and Development Fund (CCDF) received funding (see Care4Kids, 2007; Dinan and Cauthen, 2004). In 2004, there were 17,000 eligible children on the waiting list for Care4Kids funds (Jacklin 2004). Roughly 20 percent of the mothers participating in our study mentioned cost as a barrier. Only five mothers in the study had ever received state assistance for child care.
- Mothers who work non conventional hours (evenings, nights, or weekends), part-time hours, and shifts have a harder time enrolling their children in formal child care centers. A half a dozen mothers mentioned this in their interviews. Availability is also limited for infants and toddlers as well as children with disabilities. Mothers with infants had to rely on friends and family for care.
- Because there are not enough centers in poor neighborhoods, they are inconvenient and difficult to access, particularly for households without reliable transportation. Mothers detailed the difficulties of using public transportation to get their children to daycare, to get themselves to work and then to reverse it all at the end of the day.
- Mothers in the study expressed reluctance about having their child cared for by "strangers" as opposed to family members. In fact, 81 percent of the mothers expressing a negative attitude toward daycare mentioned mistrusting strangers. In comparison, only 26 percent mentioned practical issues of costs, availability and convenience (the numbers do not sum to 100 because some mothers mentioned both practical issues and trust issues). More often mothers feared benign neglect rather than deliberate abuse, worrying that inadequate supervision or unclean facilities would be harmful to their children.

Employed mothers in our study were most likely to use daycare – 20 percent of employed mothers used center-based or home-based formal care. Another one-third used informal care (family and friends, paid and unpaid), and almost one-half of the children were cared for solely by the parents – the mother or mother and father (see Table 70). This is one reason why home visitation programs are important for this population. The parents are often the sole caregivers even when they work – therefore it is important that the parents be as informed as possible about child development.

When mothers have to work and they cannot afford daycare, they often resort to less than ideal arrangements. For example, one mother worked the night shift and left her children alone in the apartment sleeping while she worked. She used a baby monitor set up at the neighbor's house: "I can leave the door unlocked for her. All she has to do is have the monitor at her house.' So far this has worked but she said, "My biggest problem is if I have to get a day job. I can't afford the daycare. Even with the state help, I can't afford the daycare."

When mothers can't afford or are reluctant to use daycare providers, they rely instead on family and friends. Forty-two percent of our participants

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Table 70. Primary Child Care Arrangements			*Primary arrangements* signifies 32 hours or more of care a week.			
Status of mother	**Center-based care**	**Home-based care**	**Family/ Friends paid**	**Family/ friends unpaid**	**None/ Parental care**	**Total**
Working	6	4	4	12	23	49
In high school	7	1	6	10	24	48
Not working or in high school	2	0	0	0	68	70
Totals	15	5	10	22	115	167

used family and close friends as child care providers. In fact, of the five mothers who received state assistance, four of the providers were either maternal grandmothers or friends of the family. While family and friends certainly have a closer bond with the child than a stranger working at a day care center, this does not always mean that the family or friend is a qualified provider. Relatives are exempt from the requirement that daycare providers be licensed by the Connecticut Department of Public Health.

In a very small number of cases, mothers relied on parents or partners who had a history of substance abuse or violence. While 27 women who were victims of child abuse allow their child to have contact with the abuser, only 10 rely on them to provide childcare. And of these, only three are "red flag' situations. These mothers use these lesser qualified providers because of necessity (they are either working or in school), and they said they could not afford to pay for childcare, and they did not trust strangers.

Some of their general mistrust was related to their violent family backgrounds and neighborhoods where mistrust is an appropriate response in a world of uncertain conditions. Some of the mistrust of formal childcare is also related to their limited power or relative inability to control the conditions of their existence. Being poor, less educated, unemployed, and members of racial minority groups, they are disadvantaged in our society. Their disadvantaged position makes them suspicious of a system that has not rewarded them. They are not only suspicious of daycare providers but we also found that many of these mothers were fearful and suspicious of law enforcement officers, the court and welfare system officials, teachers and employers. Given that these gatekeepers can imprison them, take their children, or deny them assistance, wages and healthcare, their wariness of these outsiders is understandable.

Despite their reluctance, however, mothers should be encouraged to place their children, especially older toddlers, in quality child care programs that have the potential to counteract the disadvantages associated with low-income neighborhoods. Mothers may feel more confident using formal daycare if they are informed consumers. Information about how to evaluate a child care program could be provided by the home visitor. For example, their home visitors could have a checklist that represents the criteria needed to evaluate programs, including such things as: staff-to-child ratios and group size, director and staff qualifications and training, principles and policies regarding discipline, indoor and outdoor playground safety, and health standards. In the few cases where mothers had successfully placed their children with qualified providers, it was often their home visitor who helped them. Several home visitors gave mothers the Care4Kids form, helped her complete it, and provided them with a list of all of the childcare providers in the area. Another home visitor encouraged the mother to remove her child from a poor quality home-based daycare program. One home visitor provided the mother with a videotape on daycare that helped her decide between a home-based provider and a formal daycare provider.

Home visitors can help empower parents by teaching them to be vocal advocates for their children. Parents should feel confident that they can check on their children at anytime and that they have the right to speak with daycare providers and teachers about their concerns. Mothers who have

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language barriers should have access to translators. Finally, the relationship between the home visitor and the mother provides an opportunity to develop trust. Learning to trust discerningly would be more useful than mistrusting all people all the time.

Child Sexual Abuse and Adolescent Mothers

The path from child sexual abuse to teen pregnancy (and back to child abuse) is not one all victims walk, but enough do to make the way visible. Victims of child sexual abuse are more likely to develop behavioral problems, become sexually active at a young age, take greater sexual risks (have more partners and less contraception use), to get pregnant as teenagers, suffer from depression, anxiety, eating disorders and other mental illnesses, abuse alcohol and drugs, have problems in school, and choose partners who are physically and emotionally abusive (Butler and Burton, 1990; Downs, 1993; Musick, 1993; Finklehor, 1986).

Among the mothers participating in the life stories study, the link between child sexual abuse and other problems is striking. Comparing the quarter of the teen mothers who were sexually abused as children to those who were not (or did not mention it), we find that abused girls were more likely:

- to be victims of statutory rape (22% versus 5%)
- to have abused alcohol or drugs (52% versus 16%)
- to have abusive partners (63% versus 35%)
- to suffer from a mental illness (56% versus 23%)
- to have behavioral problems (56% versus 31%)
- to drop out of high school before pregnancy (44% versus 33%).

When looking at these comparisons, it is important to remember that almost all of the mothers in our sample come from low-income families, and many have childhoods marked by violence, substance abuse, and family instability. *That is, when comparing apples to apples, we see that child sexual abuse significantly exacerbates the problems of poverty.*

As depressing as it is that a quarter of these teen moms were sexually abused as children, even more depressing is that they usually did not tell anyone about the abuse. More than one-half of the girls did not report the abuse or they told someone long after the fact. Only twelve of them told someone immediately or shortly after the abuse, five were believed and seven victims were not believed or worse, they were accused of being responsible for what had happened. Victims are less likely to be believed if the parents or guardians feel complicitous or responsible for not protecting the child or if the perpetrator is a part of the family. More than one-half of the perpetrators in our study had some familial connection to the young girl (fathers, stepfathers, grandfathers, uncles, cousins, a foster brother) and another quarter were friends of the family.

Even when they were believed, often nothing was done. Rather than prosecute, the most common response was to move the young girl away from the perpetrator.

Only three women received counseling specifically related to the sexual abuse. Another thirteen received some counseling in their lives for a variety of reasons and some discussed the abuse in that context. Hidden, denied, or poorly counseled, many young victims kept the abuse bottled inside until it slipped out in destructive ways – self-mutilation, eating disorders, suicide, depression and acute psychosis. For others, the violence from the abuse was directed outward into a pattern of early and risky sexual behavior, delinquency, truancy, drug and alcohol abuse, and unhealthy violent relations with men. This is often the emotionally chaotic and potentially abusive environment into which their children are born.

If they do not deal with their own trauma, they can become preoccupied with the baggage of their pain and subordinate the needs of the child. The potential for child abuse and neglect exists if they do not mend the damage of the early sexual abuse. One participant was adamant that she would stop the cycle of abuse, “I am not gonna molest my child. I don't care if I don’t have sex for 30 years, it would never happen - wouldn’t. I love my son too much to see my son’s life get ruined like mine is.” Within three years of this statement, this mother had a second child and two substantiated cases of child abuse filed against her; in the first case, she was charged with physical neglect because her child was sexually molested.

Home visitors should be well-trained to recognize the symptoms of sexual abuse and work pro-

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actively to provide support for the victims and to vigorously prosecute the offenders. Speaking out about the abuse, being believed, taking action against the perpetrator and receiving treatment all help the victim recover from and end the cycle of abuse. We have several mothers who did recover and have healthy relations with their children and the men in their lives. In all of these cases, the mother had a long-term relationship with a therapist; and this relationship was often strongly encouraged by someone close to her whom she trusted. By developing a close, trusting relation with the mother, the home visitor puts herself in a position to encourage the abuse victim to access counseling.

School Completion and Adolescent Mothers

Women who do not complete high school are more likely to work at low-wage jobs, receive state assistance, experience high levels of poverty, and have children who drop out of school. Resources spent to improve the rate of school completion for mothers, especially teen moms, would pay dividends to the child.

The adolescent mothers who participated in the life stories study were six times more likely to drop out of school than other students in Connecticut. Among the participants, three out of every four teen moms living in Hartford, Bridgeport and New Haven dropped out of high school, a rate more than twice the average for those urban school districts.

For the most part, the young mothers did not drop out of school because they were pregnant or had a child. *Pregnancy did not alter their trajectories – those on the path to dropping out, dropped out, and those on the path to completing high school completed high school.* Of those who dropped out of school, 56 percent of them dropped out before they became pregnant, and many of the others were already discouraged in school and falling behind by the time they became pregnant. Pregnancy and the demands of motherhood were often used as an excuse for exiting a failing situation, rather than being the cause of dropping out of school. Those doing well in school did not drop out – and this represents over one-third of the adolescent mothers. The different characteristics of the three trajectories – dropping out before pregnancy; dropping out after pregnancy; never dropping out – are outlined below and in table 3.

- **Drop Out Before:** Poverty, violence (especially domestic violence and child sexual abuse), and family instability pulled students out of schools that were not prepared to pull them back in. An erosion of skills began in elementary school and culminated in debilitating frustration when they tried to transition into high school. All mothers who dropped out of school before tenth grade had skill deficits connected to cognitive disorders, language deficiency, mental illness or having simply missed too much school. They were less integrated in school, more likely to have been in juvenile detention centers and placed in special education classes, and three times more likely to abuse drugs and alcohol as those who never dropped out.
- **Drop Out After:** The teens who dropped out after they became pregnant were some of the youngest moms in the study; thirty percent of the moms in this group were under 16 years of age when they had their first child. In this trajectory, three narratives unfolded.

⇒ Discouraged students already disengaged from school when they became pregnant. The hassles and exhaustion of pregnancy and parenting gave them an excuse to leave school. These girls often had lives as chaotic as those in the first trajectory, and they were as detached from school, the only real difference is that they became pregnant before they had time to drop out.

⇒ Latina migrants from a rural culture where young motherhood was normalized. They often became pregnant in eighth or ninth grade. Some of these mothers represented the very youngest participants in our study.

⇒ Students attending schools that did not meet the mandates of Title IX legislation requiring schools to provide equal education for all female students. Schools violated Title IX requirements by not accommodating absences and tardiness that were a part of the physical conditions of pregnancy, and by not accommodating special needs including elevator passes, extra time to get between classes, on-demand access to restrooms, and desks that fit expand-

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ing bellies. After delivery, childcare was often the primary problem. If schools did not provide on-site daycare nor accommodate long absences (resulting from bed rest, childbirth, or other health issues of both mother and child), then young parents dropped out of school.

- **Never Drop Out**: Teen moms who never dropped out of school were more likely to have a mother who had a high school diploma or GED, to have been in regular or advanced placement high school courses, and to have lived in a household with two biological parents, fewer family problems, and a car that works. Those who stayed in school had two things working in their favor: they were doing well in school before they became pregnant, and they had institutional and familial support, in particular, reliable childcare.

In some cases, having a child created an incentive to return to school, both so they could serve as a role model for their children but also to help them get a better job. Of the 68 mothers who dropped out, seven returned to high school (and of these, three had graduated at the time of the interview), and 18 returned to night school or enrolled in a GED program (and of these, eight received their diploma or certificate). The discouraged students and young Latinas were least likely to return to school or enroll in a GED program. Those nudged out of school because of hostile policies or missing programs were often forced to complete their schooling in night school or through GED programs that provided an inferior education and weakened their applications to post-secondary schools. The drop outs most likely to return to school were those who left their junior or senior year, and who did not have cognitive impairments, learning disabilities, or ESL deficiencies. They were also more likely to have reliable day care, accommodating institutions and supportive families.

Teen moms who stay in school during their pregnancy are most likely to graduate, but this reflects the type of student they were before their pregnancy. After delivery of the child, childcare issues created the most problems, and schools with day-care centers were best able to keep young mothers in school.

Identifying vulnerable moms early and working with them before delivery, home visitors can encourage moms to stay in school and help them prepare for the transition after the child is born – in particular, to have child care arranged so that they can continue with school with minimal interruption. Home visitors can also be advocates for moms, reminding them (and perhaps the school district or counselor) of Title IX mandates for equal educational opportunities for all students regardless of gender.

Vulnerabilities of "Young Young" Mothers

"Young young" moms (those under 15 years of age) represent a very small percent of all teen moms. In 2002, less than two percent of teen moms in the United States gave birth before 15 years of age (*National Vital Statistics Report*, 2003). According to the Connecticut Department of Public Health, between 2000-2005, there were a total of 286 births to mothers under age 15 (which includes a decline from a high of 66 in 2000 to only 29 in 2005), representing one percent of the total teen births in Connecticut during that period. Two-thirds of the young young moms in Connecticut live in one of the four major cities (Hartford, Bridgeport, New Haven and Waterbury), with almost a quarter residing in Hartford alone. Over half of these young young moms were Hispanic (56%), a third were African American, and about a tenth (9%) were white. In sum, the youngest moms are more likely to live in urban areas and be Hispanic or African American. As such, NFN may want to target those areas and populations to help address the vulnerabilities particular to young young moms.

Among the 108 teen moms we interviewed, 16 moms were 12 to 14 years of age when they became pregnant, and of these, seven moms were under 15 years of age when they gave birth (and one mother gave birth on her 15th birthday). Almost half of the mothers pregnant before the age of 15 were Puerto Rican (n=7). The others were biracial (n=3), white (n=2), black (n=2), Mexican, and Filipino.

While a very small subgroup of young Latinas welcomed early pregnancy, the more common reaction for these young girls was to be "scared" and "depressed." They did not intend the pregnancy and their parents were not happy. Vulnerabilities that all new moms face are exacerbated by the extreme youth of these young young moms and by

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the shame and stigma connected with the young pregnancy. They need reassurance that they can be good parents and they need help parenting.

We identified four areas of concern for young young mothers: prenatal care, statutory rape, parent-child interaction, and parent-child tension.

- **Poor Prenatal Care:** Young young girls often did not receive prenatal care until the second trimester because they were unaware of, denied, or hid their pregnancy. One mother only had six weeks of prenatal care before she delivered twins. Another said her parents did not find out she was pregnant until her eighth month. When they denied or were unaware of their pregnancy, they did not change risky behaviors (e.g., smoking cigarettes, drinking alcohol or using drugs, eating poorly). NFN will not be able to recruit these mothers into the program until the pregnancy has been acknowledged and confirmed. The earlier these young mothers can be recruited into the program, the better. The lower birth weight and higher infant mortality rates associated with adolescent childbearing is directly related to poor prenatal care and unhealthy prenatal behaviors (Taborn 1990). Home visitation programs could help to address both of these issues, but only after the pregnancy is acknowledged.
- **Statutory Rape:** For many of these very young women, their first experience with intercourse was not voluntary nor enjoyable. They often had sex because they were expected to, because they wanted to please a man who was pressuring them, or because the sexual attention made them feel desirable. Over half (n=4) of the young young moms were victims of statutory rape, defined in Connecticut as when a person three years older has oral sex or sexual intercourse with a person between ages 13 and 16 (prior to 2007 the age difference was only two years). In some cases these "victims" of statutory rape were consensual partners with "perpetrators" who were only a few years older than the young mother. In these cases, problems can derive from the state definition of statutory rape. For example, one 13-year old mother who had been in a relationship with a 17-year old for almost a year before she became pregnant was forced by the state to name the father of the baby who was charged with the crime against the wishes of the mother. "The day I had my son was the last day I saw him. They arrested him the very next day." Now, the paternal grandmother brings the child to the prison every week to see his father. The family support worker could help young couples by acting as an advocate for them in the courts and providing information regarding legal counsel. More problematic were the situations where the perpetrator was ten to fifteen years older than the young girl or when the young mother was cognitively impaired so as to make "consent" questionable. In those cases, the statutory rape represents sexual assault and the home visitor should encourage the mother to seek counseling and take action to prosecute the offender. In addition, the home visitor should be alert to the ways in which the nature of the conception (i.e., intended, accidental or forced), influences the bond between the mother and child.
- **Parent-Child Bonds:** Researchers have found that the children of young young mothers are more susceptible to behavioral and cognitive problems. Even after controlling for low income, family instability, poor schools, and disadvantaged neighborhoods, they find that young mothers interact with and provide less stimulus to the child than older moms (Chase-Lansdale and Brooks-Gunn 1991). This problem is illustrated with the case of one very young mother who became pregnant accidentally and has very little interest in the child (the father of the baby also has no interest in her or the child). The grandmother of the child enrolled the mother in the NFN program and maintains a close relationship with the home visitor. The grandmother is present at every visit, even when the mother is not. The grandmother said: "One of the hardest things right now is trying to get [the mother] to pay attention to the child. As soon as she comes home, she runs and talks on the phone. And I'm holding the baby going, 'Here, here. Take your child. Take your child.' But she doesn't want it. She doesn't want to be with him." Young young mothers benefit greatly from NFN because the home visits encourage mothers to interact with the child. In order for this to be

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beneficial, however, the mother must be present. Through the use of toys, books, and the ages and stages program, the home visitor models positive parenting practices. The home visitor can also remind the mother of the importance of providing stimulus for the child. For example, the mother mentioned above said that caring for her five-month old child was "easy, because all I have to do is feed him and change his diaper." The home visitor can show her how even at a very young age, a child is responsive and that mothers should be interacting with them. Without this interaction, the young mother may not bond with the child. One young young mother who relinquished her parenting role to the grandmother who cared for the child all day while she was in school, became despondent when her child sought comfort from the grandmother and not her. Her home visitor helped her establish an emotional bond with the child and reclaim her role as mother.

- **Child-Parent Tension:** Young young mothers are simultaneously children and parents. They are dependent on their parents or guardians. The 14-year old mother believes that having a child has made her an adult, and yet in the eyes of the state (and her parents or guardians) she is not – she cannot yet drive, she can not directly receive state assistance, and she can not set up an independent household. Her parents may treat her like a child and expect her to obey their directives. Moreover, young young moms are unique in that they can also be the victims of child abuse. The home visitation program can assist the young mom by treating her as an autonomous adult, providing her with information about parenting, and building her confidence. If the young mom is being emotionally or physically abused in the home, the home visitor can help her take action to move out of the household.

In general, the vulnerabilities of young young moms are related to their adolescence. Adolescence – the period between childhood and adulthood – is the stage where individuals are beginning to assert an individual identity and resist parental control. Having a child complicates this independence/dependence polemic. On one hand, they are more dependent on parents because of their children's needs so they cannot assert their independence as much, for example, by staying out late. On the other hand, as a parent, the adolescent mother has adult responsibilities. These responsibilities include caring for the physical, emotional and cognitive needs of the child. The family support worker can help by providing information and resources, modeling parenting strategies, and treating the young mother as an adult.

Conclusion

Our life stories analysis has been useful in understanding the daily challenges that home visitors face as well as the range of vulnerabilities that are characteristic of mothers in the program. NFN mothers may lack parenting skills because of births occurring before the mother matures out of adolescence. She may be a victim of child sexual abuse or cognitively impaired. She may struggle with a history of alcoholism or drug abuse, mental health problems, or may simply be marginalized by language barriers. In addition to parenting skills, vulnerable mothers often need help accessing quality day care, recovering from the damage of an abusive childhood, managing the deficiencies that accompany poor education, acquiring the confidence and skills to advocate for their children, interacting with state and court authorities, and negotiating their mother identities. We have learned from the mothers themselves that one of the most important roles the home visitor can play is to develop a strong trusting relationship with the mother. The value the mothers attribute to this relationship is immense. Through this relationship, the home visitor can help empower young mothers to advocate for their children, to seek help recovering from past and present trauma so they can end the cycle of abuse, to return to school or continue their education so they can better provide for their child, and to develop the emotional maturity necessary to be an effective and nurturing parent.

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Revisiting the Cultural Broker Model

by Marcia Hughes

Overview

The primary purpose of home visits is to address parenting issues, however, home visits actually involve much more. NFN families are often burdened by hardships that are difficult to fathom. Families, for example, who live in impoverished neighborhoods, are socially isolated, or lack adequate housing may not have the resources to provide the basics of safety and health. Many of the NFN parents are constantly faced with unemployment and underemployment, as well as social, cultural and sometimes language barriers. Some of the parents may also be experiencing problems such as mental illness, domestic violence, and substance abuse. Moreover, parents who have experienced poor nurturing themselves, may have poor self-perceptions and little awareness of their needs. Therefore, a major role that home visitors play is identifying family needs and helping individual family members obtain resources and connect to community services.

In order to gain a better understanding of how home visitors identify family needs and help individuals connect to community services, the Center for Social Research conducted focus groups with all ten Hartford NFN sites. The focus groups were designed to elucidate the decision making processes of the home visitors in identifying family needs, researching available community resources, and helping families to follow through. We especially wanted to learn from the front line staff about actual outcomes of referrals:

- When and how do families' needs get addressed?
- Where are there gaps in community services or barriers to accessing services?
- Do family issues get resolved? If so, which issues?
- Does the home visitors' support help to improve the circumstances of these families
- What role do program supervisors play in helping families cope with daily hardships?
- How do the home visitors, the paraprofessionals who foster relationships with these families and work with them in their homes, think change occurs?

Background

In 2005 Hartford was targeted as the first city in Connecticut to "go to scale" – expanding from two to ten program sites and screening all first-time mothers for home visitation services throughout the city. This was also a new period in the life of the program: in 2003 the Children's Trust Fund (CTF) made the decision to discontinue the national model they had adopted in 1995 and became Connecticut's Nurturing Families Network. It was a period of growth when the CTF staff, program staff, and staff from the Center for Social Research came together in several forums to discuss changes in the program model. New policies, training, and curricula emerged from these activities. Of particular relevance for this analysis, was the renewed focus and attention on the paraprofessional model, its potential advantages and pitfalls, and the central importance of the clinical supervisor role for making the paraprofessional model more effective. As a result, preparing supervisors and home visitors for the challenges of working with the NFN population and using a paraprofessional model became an explicit part of staff training. This new developmental stage and period of growth was the context under which Hartford NFN home visiting services expanded from two to ten program sites.

Hartford NFN Community Referrals

As part of an enhanced research design for the Hartford NFN sites, the number and type of community referrals made by home visitors and number of times families follow through are recorded on monthly logs. From May 2005 through the end of 2006, home visitors made over 1000 community referrals and, similarly, 911 referrals were made during the 2007 program year (refer to Table 35, p.29 of this report). For both time periods, families followed through on approximately two-thirds of these referrals. Most referrals have been for housing needs and education and employment services. It is perhaps not surprising that there are very few referrals for recreational, cultural or religious programs; given the day-to-day circumstances of many of these families, personal enrichment is often a secondary consideration. What *is* surprising,

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however, are the relatively few referrals made for mental health (32 and 38 for 2006 and 2007 respectively) and even fewer for domestic violence, and substance abuse.

Focus Group Discussions

Home visitors from each of ten sites were divided into three groups (home visitors from one program site were scheduled but did not attend); there were eight to ten participants for each group. Individual groups had a mix of home visitors from different program sites across neighborhoods with distinctly different racial and ethnic populations. Some of the home visitors worked in neighborhoods where primarily African-Americans reside and have for several generations. Other home visitors worked mainly with Hispanic families. All home visitors worked with immigrant populations. The fourth group consisted of clinical supervisors from all ten program sites. The three home visitor focus groups were in November, 2007 and the group of clinical supervisors met in December. Each of the focus groups ran for approximately one and a half hours.

Participants were asked to describe the daily struggles of families and their needs, and if possible, to identify family subgroups in terms of presenting issues. We were particularly interested in learning more about the prevalence of mental health, domestic violence, and substance abuse in the context of families' lives. As discussed in more detail below, the high prevalence of maternal depression and histories of trauma in home visiting populations and the challenges that they present for home visitation are a relatively new programmatic and research focus.

There were several core topics of discussion across all four focus groups. In this analysis we focus on the following:

- Working with families with multiple problems in communities with limited resources and institutional barriers;
- The "big three" risk factors: challenges addressing malleable risk factors;
- The cultural broker model: the relationship between the home visitor and the supervisor.
- Creating change: the relationship between the home visitor and the family, time, and turning points.

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Working with families with multiple problems in communities with limited resources and institutional barriers.

Quantitative data on the social-demographic characteristics and risk profiles of families enrolled in the Hartford expansion have not differed much from NFN families statewide with the exception that Hartford families are much more likely to be nonwhite. However, vulnerable families living in Hartford reside in communities suffering from concentrated poverty, racial and ethnic segregation and social isolation (see 2006 Annual Report, *Regional Inequality* and *Variation in Neighborhoods*). As a result, these neighborhood contexts in which the NFN program is operating are often resource-deprived with limited opportunities and eroded institutional infrastructures and, therefore, have additional negative effects on living conditions for the poor and the near-poor. "Frontline workers are confronted with the day to day struggles of vulnerable families and are pulled in a multitude of directions as they and their supervisors seek some pattern of coherent service delivery… These circumstances hone their skills as home visiting *generalists*--they need to be prepared for anything" (Black & Markson, 2001, p. 23). Several comments from the focus groups illustrate.

"You have a mother that wants to live in a better neighborhood, and even though she's working but she can't afford it. The child support that she gets from the father comes in whenever and it may not ever come in.. She goes to the State and they tell her that she makes too much money so they can't help her. But she really doesn't make too much money. She needs to pay for her shelter, food stamps, day care and whatever. She is feeling trapped. So how does she get out of this trap? When you are not used to dealing with solutions you don't know how to deal with it. And when you've got people surrounding you that are giving you negativity how in the world can you work something out?"

"*And finally when they do get a job and they want to move out the rents are so high it's ridiculous...They can't afford to pay the rent and pay the cable and the phone and the light and then also childcare and everything else. It's just like they go back to Square A."*

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"Housing is like one of the biggest issues. The Section 8 lists are 2 years long. They always open up the list but…It's a lottery. They are picking 5,000 applicants, but that's not to say they are going to get picked. It's really, really horrible...And what makes me even more angry is that a lot of these moms they are working, going to school, or both. And they are really trying hard. They are really good people. And they need a break. They need housing that will go according to their income."

Issues facing immigrant groups were among the first topics initiated across all focus groups even though the facilitator did not explicitly inquire about this.

"One of my clients is an immigrant and she is really reluctant to get any sort of assistance in her name. Because I guess the government won't let you bring relatives or friends over if you are on State assistance. So she'll do WIC for the baby but she won't do food stamps where it would be in her name, or Care for Kids. She won't do anything that would be in her name because she wants to be able to have her family come to visit or stay with her."

Focus group participants spent a significant amount of time discussing these structural barriers and describing their experiences. Many times they would try to generate ideas for each other and pass on information, suggesting different services or organizations to further explore, only to lead to more discussion about waiting lists, lack of services, and eligibility requirements. One clinical supervisor summed it up.

"I would say that 100% of my case load at some point they will or have had some kind of basic needs situation…It's cyclic and it can go to the extremes of really the basics like not having employment and really struggling with everything and moving from that end and others who are employed, but they are just minimum salary and it still doesn't cover the basics for them."

Although home visitation is not going to resolve poverty-related family problems in Hartford, if it is part of an effective network of individual and family support services, it may contribute to strengthening resiliencies and abilities to increase self efficacy. The creativity and tenaciousness of the home visitors, in their support of the families they serve, became very evident. In some cases home visitors serve as role models, in other cases they intervene themselves. It is through this process that these vulnerable mothers eventually learn how to do for themselves as described by the home visitors.

"In the beginning we do a lot of role modeling and we do a lot of things for them. 'Okay, you need to call DSS. Let's call DSS.' And then you may start by making that phone call and then they start picking up, 'Okay, this is how she spoke to the DSS worker'. Because I used to have one [NFN mother] years ago that just wanted to curse at the DSS worker all the time...And I am like 'No, you can't do that because then you are not going to get your benefits.' And I would have to sit there and make the phone call for them. And then eventually it got to the point where I would say 'Okay, now here's the phone. It's your turn.' And then you start to kind of wean yourself off. Your goal is to teach them- not just to hold their baby, bond with their baby, play with their baby, which we do a lot of that…but then eventually now 'You do it. It's your turn. And if you get stuck I am right here and then I'll take the phone.' Or 'If you don't know how to talk to your child at 3 years old about their body, let's bring a book. Let's do this together.' And then you have them do it."

"In the beginning of the program when they first come in it's like I am giving them all these resources and I am encouraging them to do this. And 'Okay, if that's something you are really interested in why don't you look into it? Why don't you pursue it? Why don't you do it?' And then once they finally get the job they call me 'I got the job!' Or 'I am starting school next month!' And I am so excited for them."

Home visitor perseverance and resourcefulness in their efforts to help the NFN families they serve were repeatedly highlighted in their stories - and the passion with which they told their stories. Additionally, rates of referrals and family follow

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through, as noted above, indicate that even in Hartford communities where resources are limited, home visitors are actively supplementing home visitation with other needed services. Still, as already noted, there were relatively few referrals made for mental health and even fewer (or none) were made for domestic violence and substance abuse. Given that these issues are highly correlated with poor parenting and child maltreatment, the need to enhance home visiting services in managing mental illness, intimate partner violence, and substance abuse, is well documented (Chaffin, 2004). Analyses of substantiated abuse and neglect reports among NFN participants, for example, show that co-occurring incidents of domestic violence, substance use, and mental health are prevalent in the majority of cases. Targeting "the big three" risk factors as well as parenting factors may yield better outcomes (Chaffin, 2004; Duggan, McFarlane, Fuddy, Burrell, Higman, Windham, & Sia, 2004).

The "Big Three"- Challenges addressing malleable (causal) risk factors

Evaluation research on national home visitation models found that home visitors are often ill-prepared to respond to maternal depression, domestic violence, and substance abuse (Gomby, 2007). These three factors, sometimes interrelated, are even more complex, more difficult to discern, and much more difficult to address than basic needs issues. Focus group participants highlighted the challenges of addressing and discussing these issues with families. For example, they often learn about illicit drug use through another family member (e.g., the grandmother), by overhearing a discussion, or by seeing signs of it in the household. Identifying its occurrence is the first challenge, intervening is another. Domestic violence is characterized by secrecy and isolation, as noted by two home visitors during a discussion on the topic:

"…and we can't touch the thing. But I am always there keeping an eye, observing what's going on and always questioning her, 'How are you doing? How are things doing', just to let her know that I am still there. But not where I can do anything much more than that."

"It's like you know there is domestic violence and she will mention it to you but then you probably see her again and everything is normal again. So it's like up and down."

"…we've been through so many domestic violence training and we know the protocols. You don't leave the [phone] number for her [in case the dad finds it and asks] 'Who brought you this about domestic violence? Who said there is domestic violence?' And get her to the point where we put her in danger. .."

Given their histories, at-risk, first-time mothers and the young children and families who participate in home visitation are especially vulnerable to mental illness. In particular, early life trauma has been well documented to increase the risk for depression and suicide (Ammerman, Putnam, Holleb, Novak, & Van Ginkel, 2005). Many of the NFN families, as measured by the Kempe Family Stress Checklist (Kempe), have experienced histories of abuse and neglect themselves. For Hartford NFN families who completed the Kempe in 2007, almost one-half (ninety-nine mothers out of 202), experienced severe forms of abuse or neglect as a child. Thirty-seven of these mothers experienced severe beatings; forty-three were raised by parents who were alcoholics or drug addicted; thirty-five were raised by *more* than two families; and thirty were removed from their home or abandoned by their parents (note that these are not mutually exclusive groups). Moreover, for many of them, social and financial circumstances at program entry indicate high levels of psychological distress and family vulnerability. For mothers who completed the Kempe in 2007, over one-half (103 out of 202), were experiencing multiple stresses. Twenty-four reported being in constant conflict with others; twenty-one were experiencing continual crisis that they felt they could not handle, and 80 of these families indicated that financial difficulties were related to much of their stress.

In discussion of the big three risk factors, program staff spent most of their time talking about signs of depression among the families they were serving. As they described it, the symptoms ranged from lack of motivation and depressed mood, to observable behaviors.

"I have a particular young lady that there's always been a question… because she is not motivated. But things continue to happen and she just doesn't seem to

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move forward. So there is always that question whether she has mental health and she is young. I mean she comes from a very complex home, but there is very little I can do when she doesn't follow through with any of the basic needs. I mean to even see beyond that."

"I know a lot of my clients they haven't been diagnosed but they are depressed...You know? And it's like 'Well, have you ever seen a doctor about it?' No. They don't even I don't think actually understand that they are depressed with everything they are doing...It's normal, I always tell them because you've been doing this your whole life it becomes normal...But they are just dealing with it...They know what they are feeling. They know what they are struggling with...But they have no idea that it's called something and that something can be done about it…"

"Well, the signs are lack of interest in things. Because when I first met her she was pregnant, but she was involved in so many different programs. But now she doesn't do much. She goes to school at [school], but she rarely goes even though she lives like in [neighborhood]. She just doesn't do it. She doesn't get out much. What I first brought out was like a checklist, like I did it in like a conversation manner to ask her how things were going or did she notice that she had a change in appetite or she was doing things differently. And she did. So I didn't want to like push the subject every single home visit because then she would stop opening the door."

The clinical issues that the parents present, as highlighted in these stories, are clearly a challenge for home visitation programs. It is widely recognized that depression in particular, undermines the positive impacts of home visitation (Leventhol, 2005; Stevens, Ammerman, Putnam, & Van Ginkel, 2002). The very risk factors most highly correlated to child maltreatment also impede the efforts of the home visitor. This became clear during focus group discussions with both home visitors and clinical supervisors. It is not that these mothers refuse home visitation services altogether. In fact, quite the contrary, not only are these home visitors able to engage these mothers, but for some mothers, the home visitor is the only one she will trust.

"It's tough. I mean I've been here for 12 years and it got to the point where I even went and became a sexual abuse advocate counselor because I felt that my hands were tied many times when moms would disclose sexual abuse. They don't want the help and they keep saying, 'No, I'll talk to you. I'll talk to you.' And I am like 'But what can I offer them', besides letting them vent about it? And I took this training because of that."

Examples of mothers refusing to get the help they needed and even refusing to talk with anyone but the home visitor were presented in every group. Barriers to obtaining treatment were also discussed, all of which are identified in the research literature (Lennon., Blome, & English 2001). Each of these issues are described below in the words of the program staff:

- Many families and even professional staff misattribute symptoms to other stressors.

"Because of the history she has shared she may have said to you…you ask her 'Have you ever been evaluated? Have you ever been diagnosed?' 'Well, no, but these are the things that I've been through and I've been exhibiting these behaviors or these symptoms for a long time' and no one has bothered to connect them somewhere to even get a psychological evaluation."

- Families often view depression as a stigma.

"Well, we see it but it's like to get the families to go and that is the issue. Like we could talk about it 'Maybe you can talk to somebody. Have a counselor' and right away the wall goes up...And it's just like 'I am not crazy.'...'I am not crazy.' And you have to back off because if you keep on they are going to close the door and be like 'I am talking to you. You think I am crazy.'"

- Often there is a lack of available services.

"It's hard when it comes to mental health [treatment], because even if you are a U.S. citizen it's difficult for us to get mental health [treatment]. So imagine for an immigrant mom. Because we have had in our case load clients that have needed mental health.

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We go crazy trying to get them in somewhere and we can't. Either the waiting list is long. It's years to come or they don't have insurance. You know?"

"It's overwhelming for the moms...And everywhere that we called there was a waiting list or there was a huge process that she had to go through. So I connected her with one agency finally and she had to go through a whole bunch of phone calls, giving a whole bunch of information over the phone. Then she had to go through an orientation process in order to even be put on the waiting list to be seen by someone. By the time all this was occurring she eventually said 'I don't want the services any more.'"

- Mothers don't always adhere to treatment.

"You see it every day… they are so beat down. They need something to build up their inner self and I don't know…And she's been on all different types of medications for depression...She goes to counseling and then she stops and she goes again."

In addition, one of the clinical supervisors discussed the cyclic nature of mental illness and how it impacts on progress.

"Because in those cases [mental health and like domestic violence and drug abuse] you may see the families get in a job and finding child care and things seem to be getting better and better and then they go down again. So it's a lot of ups and downs and a lot of cycles... Things are really, really good and they start somehow stabilizing their situation and balancing things and then it gets really bad again. Like a crisis happens and it's almost like…in my work with the home visitors I've tried to help them understand not only the cycles but what has been done is not lost, especially with mental health issues and all those things that, yeah, somebody may have another crisis and they may need to go back to the hospital or they may need medication again. But what they have already done…they have already learned that they can have a job, that they were able to do this and that for the baby, for their situation. So even though if they lose it all again they have learned that they did it once at least, so it's not all lost."

The experiences and perspective of this clinical supervisor are important for several reasons. First, even though progress is hindered, she highlights possibilities for growth. More important, without minimizing the complexity of the situation, she helps the home visitors to see this as well.

The cultural broker model: the relationship between the home visitor and the supervisor.

Former research conducted by CSR has similarly noted the institutional and systems barriers that were highlighted in this analysis as well as the complexity of family issues and multiple problems that home visitors confront on a daily basis. Prior process evaluation explored the fundamental questions of whether professional knowledge and practice can meaningfully improve the lives of families (Black & Markson, 2001; Black & Steir, 1997; Black, Erdmans, & Dickinson, 2004; Diehl, 2001). The prior analysis (1998-2000) was used to articulate and refine the paraprofessional model: It is the home visitors that have to bridge the knowledge, practices, and philosophies of the professional culture with the needs, concerns, and desires of a population that struggles with a range of issues and problems. They "broker" meaningful communication and interaction between these two distinct cultural worlds. Black and Markson noted that the paraprofesionals often identified strongly with the families. The home visitor's success often depends on personal and cultural experience with the population she is serving. Interestingly, a home visitor explained this with almost perfect clarity in one of the focus groups:

"…like I came from where a lot of these girls came from. Life was hard for me growing up. And I don't get personal with them but I let them know 'I've been there.' [Another HV: Exactly.]...I grew up in [neighborhood]. And that matters because it's like they got something physical to look at…Because then you are real to them. You are a real person... And like you said [refers to another home visitor], I don't get too personal with them, but sometimes…and I am not going to lie…with this particular mom sometimes I have to get down and dirty with her...I really, really do. Because it's like if I don't she won't get it. [Another HV: Exactly.] ...She won't understand. And I need to come off

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my professional pedestal, so to speak, and come down a couple of notches on her level and be like 'Look.' Get with the slang terms and everything for her to understand, where normally I don't talk like that. I used to, but I am here now and it's like just to show her 'You can do it.' Not to gloat to her. I don't gloat to her, but I am like 'Look. I been there. I was a young single mom, too. I had my first child at 20.'... So sometimes I have to get down and dirty with her. And she respects me...It works. It really does.

In Black and Markson's, there were two important patterns to this identification.

- In one pattern, professionalism is embraced by the home visitors as essential to establishing the appropriate boundaries between the home visitor and family and facilitating a productive relationship. In this pattern, the home visitors rely on clinical supervision in cultivating their own social capital as community advocates and in maintaining the professional objectivity needed for appropriately assessing different situations.
- In the other pattern, home visitors reject professionalism as a viable role, "protect" or shield the families from the supervisor, do not seek assistance in addressing families' problems, and ultimately, they themselves feel marginalized and are less able to achieve program goals.

Which pattern the home visitor adopts is not just a function of her skills and experience but also a function of the relationship she has with the clinical supervisor. In order for the home visitor to "buy into" the professional model, she has to believe that the clinical supervisor, as representative of the professional culture, is committed to improving the lives of the families. This happens when the clinical supervisor is willing to learn from the home visitors' experience and knowledge of the families and communities. In this way, the supervisor becomes more effective in her role as well. Thus, the role of the clinical supervisor—to listen, ask questions, and provide feedback and guidance, was also articulated and included as a central component of the paraprofessional model.

In the current research, it was the first pattern of embracing professionalism, that was repeatedly stated. The comments in the following quote were echoed by home visitors in all three focus groups.

"With all the problems that [NFN families] have sometimes you don't know whether you are coming or going. So you need someone that has their head on their shoulder and……says, 'Why don't we try this?' But first of all [clinical supervisors] have to analyze all those files. [Clinical supervisors] have to be very involved with the case. Like she said. [referring to another home visitor], they have to be involved. [Clinical supervisors] have to know the family and they have to listen to what you say. Because [we] see them every week. So it's a person that's really involved and really caring...Caring. That's the key word. They have to be caring...And understanding, too. [Clinical supervisors] understand where the families are coming from. Not trying to put them where [they] think they should be,...

It appears that the earlier attention and focus on the paraprofessional model and the period of growth under which Hartford NFN expanded "shifted" the cultural broker model in a positive direction towards that of embracing professionalism. The participants of the focus groups clearly understood the pivotal role of the supervisor. Moreover, home visitors in every focus group enthusiastically discussed how they turn to their supervisor for help in analyzing family problems and establishing personal and professional boundaries, as described in the following examples.

"Yeah. That's where your Supervisor comes in, either comes in to do a visit to see it for themselves besides what you are telling them. Or by you telling them what's been going on to develop that plan, how can we be creative? How can we address the curriculum in a different way? How can we get the baby out of the parents' room? I've tried everything and I don't know what else to do and then my Supervisor has come in and says 'Well, try presenting it this way.' "

"And we bring cases, especially when we are like against the wall... sometimes we have to back up and hear someone else see what we are not seeing maybe and make suggestions. And those suggestions are put on the table and if we feel, 'You know what? Maybe that's true. I should approach it this way.' So case conferences as well as your Supervisor is the best way to look

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at a case.

"The Supervisor is crucial for our work. Sometimes I feel really overwhelmed and drained and I sit with her and she can be very positive and help us a lot with our clients. [others agree]…And we do supervision every week. [laughs]…Oh, yeah. Because sometimes she has to tell us, 'Okay, don't take it personal' about certain things...And then I start taking it personal just a little bit. And she is like 'Don't take it personal. It's okay. Let's think about how we can work around it, how we can make it better.' Yeah, supervision is crucial"

"Even joint supervision is crucial because we all sit together and we talk about our cases. We pick a case that we want to talk about, whether it's positive or negative, and we kind of bounce ideas off of each other. Give each other advice or 'Did you try this? Did you call here?' So it's really, really good."

"Well, we use each other a lot. [laughs] But then our Supervisor…we may not have formal supervision all the time but we always keep her informed and we are in her office a lot, too, to try to get ideas or ask questions or whatever…It's each other. Sometimes that's all you need is to vent…Yeah, we have a lot of informal supervision. We go burst into supervisor's cubicle. I sit up on her table. I don't even sit in the chair. I just plop up on the counter and I am like 'Help!' [laughter]"

Creating change: the relationship between the home visitor, time, and turning points.

During these group discussions, it seemed that the importance of the supervisory role could not be overstated by the home visitors. Similarly, as gleaned from their many stories and comments, the power of the home visitors' experiences and knowledge of these vulnerable families and communities can also not be overstated. When asked if their efforts made a difference, that is, Do you see change occur among these families?, it was surprising, given the stories they had shared, to hear them all immediately respond almost in unison:

⇒ *Yeah.*

⇒ *Yeah.*

⇒ *It's with time.*

⇒ *Consistency.*

⇒ *Encouragement.*

⇒ *Encouragement, yeah.*

⇒ *Definitely recognizing the efforts that [families] are putting in…*

⇒ *Persistence…because they don't always get that from like their mother or whoever, their spouse or whoever.*

⇒ *Sometimes with the moms that we just have to remind them 'Remember this was your goal?' and as soon as they are done with that goal praise them on it. And that's what gets them there.*

⇒ *Yeah.*

⇒ *Yeah.*

<u>The relationship between the home visitor and the family.</u>

As noted, the emphasis of the paraprofessional model is on making connections with families; therefore, home visitors are hired based on their ability to identify and empathize with families' struggles and on facilitating a mentoring relationship with these families. The difficulties doing this with a marginalized, high-risk population were duly noted.

"They've been to a lot of programs, whether they are young or not. They've been through some other program or some other system and when they've failed they are looking at you 'What are you going to do? Are you going to stay for a while and leave?' And the consistency and we continue being there, even when they don't want us there sometimes, they are very courteous about having us there…And you are like competing with the TV or the radio or this or that and you are like 'Okay, what I am doing here that she wants me here?' [laughter] And then eventually it clicks."

"Like I said I gave them the utmost respect and just really gave them the chance to open up to me. No pressure. I knew eventually it would break. After a while it broke and they opened up to me. But I mean we've got to put ourselves in these family's shoes. They don't know us. They don't know who we are coming into their home. It takes time to trust a stranger…to trust anybody, let alone a stranger. I really think it's how you interact and deal with that family when you are faced with that...I think that's like a major thing to get on the floor and really involve yourselves in the activities. It

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just takes time and patience...Yeah, I knew it would happen. I just knew it would happen." [laughs]

"Because they pick up on your sincerity and your genuineness…if that's a word. They pick up on your cues and once they know you are not there to judge them…And I think it's just like connecting all the members in that household. If you have a grandmother that's feeling you out and not……and not trusting you or whatever you have to make an effort to really engage everybody in that home..".

"It's been a little while. And it's little…Little steps… baby steps. Little steps and praising the positive and ignoring and overlooking a lot of the setbacks, overlooking the negatives...The overlooking a lot but you have to praise every little thing…And no matter how they are when I go there…sometimes they are angry at each other, yelling at each other and not very receptive…I sit there and listen. And then when she's ready I will…but she knows…I said 'Do you think it's not a good time for me? Maybe I can reschedule because I don't want to give you more stress.' Once they know that, 'Yeah, I don't want to cause you more stress. I am here to support you. Not to cause you more stress.' So then they welcome you back because you are not judgmental. You are just there. They know you are supportive."

Time

Being consistent, genuine, and non-judgmental were repeated themes. And in order to get these messages across, it takes time. It is not unusual for family progress to go up and down for a year before it stabilizes, as noted by one of the clinical supervisors:

"…it takes almost the first year for that family and the [home visitor] to negotiate what is this relationship about. There is a lot of back and forth…, 'I am not going to provide you with everything. What is my role here? What are really the resources out there. What is my role connecting to the resources?' And that first year is so difficult and intense and also the needs of the family. And then after that period then comes the stabilization..."

And still, it often takes a very long time for families to have the trust and hope essential to make improvements:

"...at the beginning you can make really many referrals but they are not going to go because, first of all, they are not used to that kind of thing. And then, second of all, they don't know us that well to find out if it's the right thing for me. I mean 'Who is she to come and tell me that'? So once you are there…because I am finding out, I've been there 2 ½ years…I am finding that now they will do as I refer because they already know me. They know that I've never led them wrong. So now they trust you. And I have one that's going to anger management. Before if I had mentioned that she would have hit the roof." [laughter]

The Turning Points

Over time, these seemingly intangible interventions: consistent support, genuineness and acceptance, eventually lead to "turning points," as noted by one home visitor:

"There are different turning points. There is a turning point, I believe, that when that mom sees 'Oh, she's okay. She is really here to help me. She is not here to judge me' and they start to open up and they start to disclose all of these things that have happened in their history or what's going on in the home."

When observable change does occur, it seems to almost take the home visitors by surprise.

"I had a case and I don't know I think I was almost ready to give up. I swear I was not getting through to this family. And then one day I get a call. The mother and the father got a job and they were just thanking me so much. They were like 'I know you didn't think it was sinking in. But I've been determined and I got a job.' [laughter]…forget about the year of frustration, that makes the difference. It built my morale up. So it's just…sometimes you don't think you are getting through but you are. You know? They may not say 'Oh, I got that', but they are getting it...They are listening to us...They know that…they've told me, 'I owe it all to your program. You guys are the only ones that stick with me.'... And that's good. It works. And it sinks in. It takes time."

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Clinical supervisors had similar perspectives but clearly were speaking from more distance:

"You almost see them changing physically. Like they are maybe depressed and not taking care of themselves. I know that they also just had a baby so they are probably tired and whatever, but after they start working and they go back to school and probably they find an apartment you just see them glowing. Like you don't need to ask them if they are finding a house. It's like 'You are doing good. I know that you are doing good.'"

"It's very interesting because then you have to study the relationship, you have to know what each other is about and then [mothers] go to school and they get a job and they keep going and [home visitors] lose them. [laughs, [many talking at once]. [Mothers] don't have time. They are like really busy….[Another clinical supervisor responds:] I mean it's literally sad at the same time because they are…you see them growing and doing something for themselves and for the kid, too."

Conclusion

Analyses of these focus groups reveal the difficulty of addressing the multiple problems the NFN families deal with on a day-to-day basis, in particular "the big three" risk factors. However, the cultural broker model provides the mechanism for doing it artfully and effectively. It comes down to relationships, identifying problems with support and supervision, finding effective strategies and services, and time. Moreover, the experiences and knowledge base the home visitors have of these vulnerable families and the communities they live in are a powerful resource for informing practice and policy. The cultural broker model should be revisited and further refined to address the very issues that often challenge home visitation practice.

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